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

AUGUST 7, 2025
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

Isabel Becerra, Chair
Maura Byron
Blair Contratto
Catherine Green, R.N.
Veronica Kelley, DSW, LCSW
Supervisor Vicente Sarmiento, Vice Chair
Supervisor Doug Chaffee
Norma García Guillén
Brian Helleland
José Mayorga, M.D.
Supervisor Janet Nguyen, Alternate

CHIEF EXECUTIVE OFFICER
Michael Hunn

OUTSIDE GENERAL COUNSEL
James Novello
Kennaday Leavitt

CLERK OF THE BOARD
Sharon Dwiers

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

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

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

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at: **https://us06web.zoom.us/webinar/register/WN_mMW3jBBcTue8VfUU67f9HQ** to Join the Meeting.
Webinar ID: **850 6302 1719**
Passcode: **114037** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS
1. Chief Executive Officer Report

ADVISORY COMMITTEE UPDATES
2. Member Advisory Committee and Provider Advisory Committee Update

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

CONSENT CALENDAR
3. Minutes
   a. Approve Minutes of the June 5, 2025 Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the March 12, 2025 Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

4. Approve New Appointments and Reappointments to the CalOptima Health Whole-Child Model Family Advisory Committee

5. Approve Reappointments and Appointments to the CalOptima Health Board of Directors' Member Advisory and Provider Advisory Committees

6. Authorize and Direct Execution of Amendments to the Companion Contract and the Primary Contract with the California Department of Health Care Services for the CalOptima Health Program of All-Inclusive Care for the Elderly

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

8. Authorize the Chief Executive Officer to Negotiate and Execute a Contract with OpenText for a Cloud-based Faxing Solution

9. Approve Actions Related to Covered California Administrative Services Agreements

10. Approve Modifications to the CalOptima Health Capitalization Policy

11. Approve Modifications to Policy GA.5004: Travel and Other Reimbursable Expenses

12. Receive and File:
    a. May and June 2025 Financial Summaries
    b. Compliance Report
    c. Government Affairs Reports
    d. CalOptima Health Community Outreach and Program Summary
    e. Fiscal Year 2025 Strategic Plan Performance Executive Status Report April - June 2025

REPORTS/DISCUSSION ITEMS

13. Select and Enter into Grant Agreement with Street Medicine Provider

14. Approve Actions Related to CalOptima Health Policy AA.1400: Grant Management

15. Approve New CalOptima Health PACE Policy PA.9003: PACE Letters of Support

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

17. Ratify Amendment to Grant Award Agreement with Coalition of Orange County Community Health Centers for Population Health and Value-Based Care Transformation

18. Ratify Amendments to the Grant Agreements with CalOptima Health Comprehensive Community Cancer Screening and Support Grantees

19. Ratify Extension of Grant Award Agreement with Mind OC for the Be Well OC Irvine Campus

CLOSED SESSION

CS-1. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Government Code section 54956.9(d)(4): 2 cases

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors on August 7, 2025 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_mMW3jBBcTue8VfUU67f9HQ

To **Join** this webinar:
https://us06web.zoom.us/s/85063021719?pwd=0p47EKgWhFDaRgoNrhDGaxcFMLdy8S.1

Phone one-tap:
+16694449171,,85063021719#,,,,*114037# US
+12532158782,,85063021719#,,,,*114037# US (Tacoma)

Join via audio:
+1 669 444 9171 US
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
+1 719 359 4580 US
+1 720 707 2699 US (Denver)
+1 253 205 0468 US
+1 507 473 4847 US
+1 564 217 2000 US
+1 646 558 8656 US (New York)
+1 646 931 3860 US
+1 689 278 1000 US
+1 301 715 8592 US (Washington DC)
+1 305 224 1968 US
+1 309 205 3325 US
+1 312 626 6799 US (Chicago)
+1 360 209 5623 US
+1 386 347 5053 US

Webinar ID: 850 6302 1719
Passcode: 114037
International numbers available: **https://us06web.zoom.us/u/kSQ6ddAZS**

CalOptima Health

MEMORANDUM

DATE: July 31, 2025

TO: CalOptima Health Board of Directors

FROM: Michael Hunn, Chief Executive Officer

SUBJECT: CEO Report — August 7, 2025, Board of Directors Meeting

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

A. Covered California Monthly Update

CalOptima Health continues to prepare for the launch of a Covered California line of business, effective January 1, 2027. Following the Board's approval on June 5, staff submitted an initial filing on June 16 to expand the scope of CalOptima Health's current Knox-Keene Act license with the California Department of Managed Health Care (DMHC), which is required to offer a commercial insurance product. Since then, DMHC has provided comments and we are in the process of responding and updating our exhibits. Deloitte Consulting LLP also recently completed its operational gap analysis, prompting the initiation of several new workstreams to discuss and implement solutions in order to achieve operational readiness over the next year. Lastly, CalOptima Health continues to negotiate provider contracts and execute amendments with several existing vendors to include Covered California in their scopes of service.

B. Medicaid Data Sharing Confirmed

On July 17, the Associated Press confirmed that U.S. Immigration and Customs Enforcement (ICE) officials will be given access to the personal data of the nation's 79 million Medicaid enrollees, including home addresses and ethnicities, to locate immigrants who may not be living legally in the United States, according to an agreement signed on July 14 between the U.S. Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Homeland Security (DHS), which oversees ICE. The full agreement has not yet been made public. In response to earlier reports, California Attorney General Rob Bonta previously announced that the California Department of Justice is leading a 20-state lawsuit against the federal government, alleging that such actions violate federal privacy laws. The lawsuit requests the federal district court to block the transfer of new data from CMS to DHS as well as the use of current data by DHS for immigration enforcement purposes. CalOptima Health continues to support members during these difficult times in the following ways:

- **Webpage With Resources**
  To help our members who may be hesitant to seek care in person, CalOptima Health created an Access to Care webpage that shares a list of providers who offer telehealth, our nurse advice phone line, medicine home delivery options and virtual mental health services. We also included local immigration resources. The new webpage has been promoted broadly with

members and the community through a mailing, social media postings and electronic newsletter alerts to community-based organizations, stakeholders and providers.

- **Texting Outreach**
  In early July, CalOptima Health launched a multilingual texting campaign to promote the new Access to Care webpage described above. The campaign reached nearly 300,000 members' cell phones (many representing multiple members in a household) and achieved an aggregate engagement rate of 19.72%, aligning with other successful member benefit campaigns.

C. CalOptima Health Contracted Hospital KPC Orange County Global Medical Center Update

On July 12, the OC Register published an article that outlined operations and clinical issues at Orange County Global Medical Center (OCGMC), as cited by a February 2025 California Department of Public Health (CDPH) report and a lawsuit being brought by a former stroke patient. CalOptima Health contacted CEO Peter Baronoff to discuss our concerns. We have also discussed the matter with OC Health Care Agency Director Dr. Veronica Kelley related to Orange County Emergency Medical Services' use of OCGMC as a stroke receiving center. In short, the hospital is in compliance with its CDPH licensure and is meeting the Conditions of Participation for Medicare and its Accreditation by the Joint Commission. We will continue to monitor their compliance. OCGMC did fail to notify CalOptima Health of the CDPH Survey and its findings, as they are required to do per their contract. Our team will meet with OCGMC on a weekly basis to ensure ongoing compliance, consistent with the action plan filed with CDPH. We will monitor the hospital weekly for the next 90 days and longer if necessary. Please note that we have always had and will continue to have routine weekly clinical rounds on all inpatients (CalOptima Health Community Network and health network members) during which we address any clinical issues. On average, OCGMC has ~1,200 ED visits/month and ~300 acute admissions/month of CalOptima Health members (direct and health networks combined).

D. Grants Support Efforts to Expand Affordable Housing Options

- **Eli Commons Groundbreaking**
  On June 25, CEO Michael Hunn spoke at a groundbreaking for Eli Commons, a new permanent supportive housing development in Anaheim. The Eli Home for Abused Children is a faith-based organization that serves more than 1,000 abused children and their mothers, at-risk youth and families by providing them with shelter, counseling and other services. CalOptima Health provided a foundational $5 million grant through the Department of Health Care Services' Housing and Homelessness Incentive Program.
- **La Veta Village Dedication**
  On July 16, Chief Operating Officer Yunkyung Kim spoke at a dedication ceremony for the newly completed La Veta Village, a 20-bed affordable housing development featuring three refurbished historic homes in the City of Orange. Developed by HomeAid Orange County/Los Angeles, a nonprofit leader in housing development for those in crisis, the project leveraged building industry relationships to transform the property. CalOptima Health contributed $1.4 million to the project that will serve vulnerable seniors and families facing homelessness.

E. CalOptima Health Implements Improvement Strategy for Annual Health Outcomes Survey

CalOptima Health prepared for the annual Health Outcomes (HOS) Survey, conducted annually with Medicare members between July and November. The survey assesses the physical and mental health of a patient over a two-year period. The results are used to improve care delivery, support quality improvement efforts for better patient health outcomes and are used for Medicare Advantage Star Ratings. We've completed the following to support the HOS measure outcomes:

- Created several patient-facing materials (brochures, conversation starters and posters) related to the HOS measures. Our ask to PCPs is that they discuss these topics with their patients during their annual exam/Annual Wellness Visit (AWV) and other preventive visits as applicable.
- Provided a copy of the materials to health network partners and reviewed them during our July Quality Update meetings.
- Provided talking points to Provider Relations staff, who are meeting with the high-volume OneCare provider groups to review the materials.
- Presented the topic at the June Community Clinic Forum.
- Multiple teams at CalOptima Health have partnered to contact CalOptima Health Community Network members telephonically and via email. We are using HRA response data to provide targeted education and support.

The survey results are used to improve care delivery, support quality improvement efforts for better patient health outcomes and for Medicare Advantage Star Ratings.

F. President Signs Federal Budget Reconciliation Bill

On July 4, U.S. President Donald Trump signed into law a Fiscal Year 2025 budget reconciliation package, known as H.R. 1: One Big Beautiful Bill Act, following final passage by the U.S. Senate and U.S. House of Representatives earlier in the week. **Attached** is a one-page highlight of key Medicaid provisions that were included in the enacted legislation and that will likely be of significant impact to CalOptima Health.

Now that this legislation has become law, CalOptima Health will focus on further understanding the specific implementation requirements and working with federal and state officials to minimize disruption to our members and providers. While we didn't achieve the outcome we hoped for in Congress, our advocacy efforts were not in vain. The relationships we built and the concerns we raised will be crucial as federal agencies — particularly the U.S. Centers for Medicare and Medicaid Services (CMS) — now begin the regulatory process to effectuate these new policies over the coming months and years. CalOptima Health will continue to coordinate advocacy and implementation efforts with our Congressional delegation, trade associations, lobbyists, and local providers and stakeholders. We will also engage closely with our state counterparts as the California State Legislature and the California Department of Health Care Services (DHCS) respond to the forthcoming CMS regulations through amended state budgets and Medi-Cal policy guidance.

G. Governor Signs Final State Budget Bills

In late June, Governor Gavin Newsom and leadership of the California State Legislature reached a final FY 2025–26 state budget agreement following nearly two weeks of negotiations to reconcile the governor's May Revision proposal and the Legislature's counterproposal. Subsequently, the State Senate and State Assembly passed a "budget bill junior" and several "trailer bills" that incorporated the final agreement into the Legislature's previously passed counterproposal. Governor Newsom finished signing these budget bills into law on June 30 ahead of the start of FY 2025–26 on July 1. A detailed analysis regarding impacts to CalOptima Health will be shared in a future update.

H. CalOptima Health Gains Media Coverage

- On June 5, Chief Medical Officer Richard Pitts, D.O., Ph.D., was featured in a KNX radio segment on the new COVID-19 variant and summer surge. Since the segment first aired, it has been widely syndicated.

- On June 27, the Capistrano Dispatch ran a profile of a recent graduate and recipient of CalOptima Health's stipend program supporting Master of Social Work students at California State University, Fullerton. CalOptima Health is investing $5 million over five years to expand the number of social workers serving Medi-Cal members in Orange County.
- On July 14, Spectrum TV aired a feature-length segment about our Street Medicine Program. Reporter Jo Kwan rode along with the Costa Mesa care team to see firsthand the life-changing interactions and compassionate care given to those living on the streets. The segment also featured an interview with Kelly Bruno-Nelson, DSW, Executive Director of Medi-Cal/CalAIM.
- On July 21, NewSantaAna ran an article on CalOptima Health's $1.5 million grant to Orangewood Foundation and Orange County Probation to support temporary housing for justice-involved teens as they transition back to their families and daily responsibilities.
- On July 12, KQED, one of the largest NPR affiliates in the country, interviewed CEO Michael Hunn for a digital piece titled "On Medi-Cal? When to Expect New Rules, Higher Costs and Enrollment Freezes" on the upcoming changes to Medi-Cal.
- On July 22, the Voice of OC published an article regarding CalOptima Health and our reserves.
- On July 22, KNX Radio ran a feature-length piece including an interview with Kelly Bruno-Nelson, DSW, Executive Director of Medi-Cal/CalAIM, talking about CalOptima Health's role in investing in affordable housing projects like the newly opened La Veta Village in Orange.

CalOptima Health

Fast Facts
August 2025

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

Membership Data* (as of June 30, 2025)

Total CalOptima Health Membership

904,213

Program	Members
Medi-Cal	886,034
OneCare (HMO D-SNP)	17,664
Program of All-Inclusive Care for the Elderly (PACE)	515

*Based on unaudited financial report and includes prior period adjustments.

Key Financial Indicators (for 12 months ended June 30, 2025)

	Dashboard	YTD Actual	Actual vs. Budget ($)	Actual vs. Budget (%)
Operating Income/(Loss)	●	$251.8M	$514.8M	195.7%
Non-Operating Income/(Loss)	●	$103.7M	$39.1M	60.7%
Bottom Line (Change in Net Assets)	●	$355.5M	$554.0M	279.1%
Medical Loss Ratio (MLR) *(Percent of every dollar spent on member care)*	●	89.8%	---	(9.3%)
Administrative Loss Ratio (ALR) *(Percent of every dollar spent on overhead costs)*	●	5.2%	---	1.8%

Notes:
- For additional financial details, refer to the financial packages included in the Board of Directors meeting materials.
- Adjusted MLR (without the estimated provider rate increases funded by reserves) is 85.6%.

Reserve Summary (as of June 30, 2025)

	Amount (in millions)
Board Designated Reserves*	$1,584.4
Statutory Designated Reserves	$132.4
Capital Assets (Net of depreciation)	$98.6
Unspent Balance of Allocated Resources	$404.5
Unspent Balance of Board Approved Provider Rate Increase**	$315.7
Unallocated Resources*	$265.0
Total Net Assets	$2,800.6

* Total of Board-designated reserves and unallocated resources can support approximately 168 days of CalOptima Health's current operations.

** 5/5/24 meeting: Board of Directors committed $526.2 million for provider rate increases from 7/1/24–12/31/26.

Total FY 2026 Annual Budgeted Revenue **$4.7 Billion**

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

CalOptima Health Fast Facts

August 2025

Personnel Summary (as of July 12, 2025, pay period)

	Filled	Open	Vacancy % Medical	Vacancy % Administrative	Vacancy % Combined
Staff	1,352.25	85	40%	60%	5.91%
Supervisor	83	4	0%	100%	4.60%
Manager	113	14	14.29%	85.71%	11.02%
Director	73	10.5	33.33%	66.67%	12.57%
Executive	22	0	---%	---%	---%
Total FTE Count	1,642.25	114.5	47.89%	52.11%	6.52%

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

Provider Network Data (as of July 23, 2025)

	Number of Providers
Primary Care Providers	1,308
Specialists	7,535
Pharmacies	607
Acute and Rehab Hospitals	43
Community Health Centers	68
Long-Term Care Facilities	207

Treatment Authorizations (as of May 31, 2025)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	37.27 hours
Prior Authorization – Urgent	72 hours	15.33 hours
Prior Authorization – Routine	5 days	1.89 days

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

Member Demographics (as of June 30, 2025)

Member Age

0 to 5	8%
6 to 18	22%
19 to 44	35%
45 to 64	21%
65 +	14%

Language Preference

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

Medi-Cal Aid Category

Expansion	38%
Temporary Assistance for Needy Families	37%
Seniors	12%
Optional Targeted Low-Income Children	7%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

CalOptima Health

Provider Network Trend

August 2025

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

CHCN and Health Networks

Total Providers [1]

Provider Type	2024 – Q2	2024 – Q3	2024 – Q4	2025 – Q1	2025 – Q2	YOY Net Δ
PCP [2]	1,296	1,308	1,313	1,312	1,301	5
Specialist (Physicians)	6,878	7,056	7,017	7,070	7,479	601
Hospitals [3]	41	41	41	41	41	0
Community Health Centers [4]	64	65	65	65	68	4
Long Term Care	200	206	206	207	207	7
Behavioral Health [5]	2,220	2,256	2,273	2,529	2,579	359
ECM	32	32	32	31	32	0
Community Support	99	102	103	102	103	4

Medi-Cal

Provider Type	2024 – Q2	2024 – Q3	2024 – Q4	2025 – Q1	2025 – Q2	YOY Net Δ
PCP [2]	1,099	1,084	1,087	1,087	1,076	-23
Specialist (Physicians)	6,211	6,435	6,420	6,464	7,173	962
Hospitals [3]	37	37	37	37	37	0
Community Health Centers [4]	63	63	63	63	66	3
Long Term Care	196	202	202	203	203	7
Behavioral Health [5]	2,123	2,176	2,177	2,436	2,495	372
ECM	32	32	32	31	32	0
Community Support	99	102	103	102	103	4

OneCare

Provider Type	2024 – Q2	2024 – Q3	2024 – Q4	2025 – Q1	2025 – Q2	YOY Net Δ
PCP [2]	1,091	1,098	1,099	1,096	1082	-9
Specialist (Physicians)	5,208	5,407	5,437	5,488	5,844	636
Hospitals [3]	36	36	36	36	36	0
Community Health Centers [4]	57	58	58	58	62	5
Long Term Care	200	206	206	203	207	7
Behavioral Health [5]	599	613	649	668	713	114

PACE

Provider Type	2024 – Q2	2024 – Q3	2024 – Q4	2025 – Q1	2025 – Q2	YOY Net Δ
PCP [2]	5	5	3	3	4	-1
Specialist (Physicians)	3,253	3,405	3,457	3,549	4,033	780
Hospitals [3]	29	29	29	29	29	0
Community Health Centers [4]	0	0	0	0	0	0
Long Term Care	65	65	66	67	69	4
Behavioral Health [5]	97	96	103	106	116	19

Provider Network Trend

August 2025

CHCN Only

Total Providers [1]

Provider Type	2024 – Q2	2024 – Q3	2024 – Q4	2025 – Q1	2025 – Q2	YOY Net Δ
PCP [2]	673	680	678	677	671	-2
Specialist (Physicians)	6,216	6,418	6,335	6,384	6,841	266
Hospitals [3]	37	37	37	37	37	0
Community Health Centers [4]	56	56	56	56	58	2
Long Term Care	196	202	202	203	203	7
Behavioral Health [5]	2,198	2,234	2,247	2,500	2,541	343
ECM	32	32	32	31	32	0
Community Support	99	102	103	102	103	4

Medi-Cal

Provider Type	2024 – Q2	2024 – Q3	2024 – Q4	2025 – Q1	2025 – Q2	YOY Net Δ
PCP [2]	652	657	656	653	650	-2
Specialist (Physicians)	5,804	6,041	5,988	6,026	6,791	987
Hospitals [3]	34	34	34	34	34	0
Community Health Centers [4]	56	56	56	56	58	2
Long Term Care	196	202	202	203	203	7
Behavioral Health [5]	2,104	2,157	2,155	2,411	2,471	367
ECM	32	32	32	31	32	0
Community Support	99	102	103	102	103	4

OneCare

Provider Type	2024 – Q2	2024 – Q3	2024 – Q4	2025 – Q1	2025 – Q2	YOY Net Δ
PCP [2]	564	572	569	571	565	1
Specialist (Physicians)	4,470	4,691	4,706	4,746	5,136	666
Hospitals [3]	31	31	31	31	31	0
Community Health Centers [4]	46	46	46	46	48	2
Long Term Care	196	202	202	203	203	7
Behavioral Health [5]	584	598	634	652	699	115

PACE

Provider Type	2024 – Q2	2024 – Q3	2024 – Q4	2025 – Q1	2025 – Q2	YOY Net Δ
PCP [2]	5	5	3	3	4	-2
Specialist (Physicians)	3,253	3,405	3,457	3,549	4,033	780
Hospitals [3]	29	29	29	29	29	0
Community Health Centers [4]	0	0	0	0	0	0
Long Term Care	65	65	66	67	69	4
Behavioral Health [5]	97	96	103	106	116	19

Footnotes:

[1] Unique count of Provider by NPI (does not include count of each practice location per provider)

[2] Includes Primary Care Physicians, FQHCs and Long Term Care facilities acting as Primary Care Providers

[3] Includes Acute, Rehab and Long Term Acute Care Hospitals

[4] Community Health Centers includes FQHCs, FQHC look-alike and Community Clinics

[5] Includes Practitioners and Behavioral Health Groups

H.R. 1: One Big Beautiful Bill Act

Fiscal Year 2025 Federal Budget Reconciliation

As signed into law on July 4, 2025

Please note that H.R. 1 includes several distinct implementation dates over the coming years, but there are no major immediate impacts to Medicaid beneficiaries until 2026.

In addition, most Medicaid provisions of H.R. 1 still require federal rulemaking by the U.S. Centers for Medicare and Medicaid Services (CMS) and subsequent state implementation by the California State Legislature and/or the California Department of Health Care Services (DHCS).

MEDICAID HIGHLIGHTS
Eligibility
Work, community service and/or education requirement of **80 hours per month** for able-bodied adults ages 19–64 (with exceptions for short-term hardship, parents with dependents under age 14, pregnant women, medically frail, caregivers and others), effective **December 31, 2026** (or no later than **December 31, 2028**, at the discretion of the U.S. Secretary of Health and Human Services [HHS])
Increased frequency of eligibility redeterminations for Medicaid Expansion (MCE) enrollees from annually to **every six months**, effective **December 31, 2026**
Financing
Prohibition on any new or increased provider taxes, effective **immediately**
Existing provider taxes (except those related to nursing or intermediate care facilities) would be gradually reduced from the current maximum **6.0%** hold harmless threshold to a new **3.5%** hold harmless threshold by **0.5% annually** from **October 1, 2027, through October 1, 2031**
Significant restrictions on current Managed Care Organization (MCO) taxes, which could effectively **repeal** California's MCO tax that was recently made permanent by Proposition 35 (2024), with a potential winddown period of up to **three fiscal years** at the discretion of the HHS Secretary
Cap on new state-directed payments (SDPs) at **100%** of the Medicare payment rate, effective **immediately**; gradually reduces existing SDPs to that cap by **10% annually**, starting **January 1, 2028**
Emergency Medicaid services provided to all undocumented beneficiaries would be subject to the traditional Federal Medical Assistance Percentage (FMAP) — **50%** in California — regardless of the FMAP for which those would otherwise be eligible, effective **October 1, 2026**
Access
Cost-sharing for MCE enrollees with incomes of **100–138%** Federal Poverty Level (FPL), not to exceed **$35** per service and **5.0%** of total income, and not to be applied to primary, prenatal, pediatric, behavioral or emergency care, effective **October 1, 2028**
Temporary **one-year** prohibition on all Medicaid funding to Planned Parenthood, effective **immediately**

Board of Directors Meeting
August 7, 2025

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

Report to the Board

The Member Advisory Committee (MAC), and the Provider Advisory Committee (PAC) held a regular joint meeting on June 12, 2025.

The MAC and PAC both approved the August 2025 - December 2026 joint meeting schedule and approved their individual committee's slate of candidates.

Michael Hunn, Chief Executive Officer, expressed his gratitude to the members of the advisory committees for their volunteer efforts and crucial feedback, which helps leadership stay informed. He emphasized the importance of incorporating committee input into the planning and decision-making process. He noted that CalOptima Health currently serves about 901,000 members in Orange County, with a significant portion being undocumented individuals. He noted that changes in eligibility and potential co-pays could lead to a decline in enrollment by up to 200,000 individuals, raising concerns about where these individuals will go for their healthcare and discussed the need for a plan to address the healthcare needs of undocumented individuals and children who will lose continuous eligibility. He stressed the importance of community support services and expressed uncertainty about future funding and plans.

Mr. Hunn discussed how CalOptima Health's budget is heavily reliant on state and federal funds, and a significant drop in enrollment could reduce revenues by $1 to $1.5 billion. He noted that despite low administrative overhead, the health plan must remain efficient and prepared for potential financial challenges. He also noted the importance of maintaining reserves to ensure the plan's stability and discussed the financial challenges facing the health plan. Mr. Hunn emphasized that existing reserves would be quickly depleted given the $350 million monthly spend and the importance of scenario planning for potential membership declines and the need to identify community resources and philanthropic support for those who may lose their health insurance. Mr. Hunn highlighted the abundance of healthcare resources in the county but also acknowledged the financial strain on those resources if membership and reimbursements were to decline. He noted that a major concern is the potential impact on hospital emergency rooms, which are required by federal law to treat all patients regardless of their ability to pay. Mr. Hunn stressed the need for collaboration with various stakeholders, including advisory committees, medical groups, and community clinics, to address these challenges. He also discussed the importance of staying informed about state and federal budget decisions and the potential penalties for covering undocumented individuals.

Mr. Hunn also acknowledged the fear and anxiety among the community, particularly among undocumented individuals, which has led to a decline in clinic visits and encouraged the use of telehealth and flexible clinic hours to help people feel safe accessing care. Mr. Hunn also highlighted the mental health impact of these issues and the importance of supporting both staff and community members. He urged everyone to take care of themselves and stay engaged in the ongoing discussions and planning efforts.

Carmen Katsarov, Executive Director, Behavioral Health Integration, and Linda Lee, Executive Director, Quality Improvement, provided updates on behavioral health services for Applied Behavior Analysis (ABA) providers. Ms. Katsarov noted that the Department of Health Care Services (DHCS) has implemented a new method for ABA providers to apply for Medi-Cal enrollment, effective May 5, 2025 and noted that applications submitted by June 30, 2025, would receive an effective enrollment date of July 1, 2025.

Ms. Lee discussed how existing ABA providers already contracted with CalOptima Health must now also enroll with Medi-Cal and that ABA providers were encouraged to meet the June 30 deadline to avoid delays, as applications received after this date will be processed on a first-come, first-served basis, which could take six months to a year. She noted that providers who miss the deadline will have a 90-day grace period to apply and submit verification of enrollment, during which they will receive provisional credentialing for 120 days. Failure to enroll within this period would result in contract termination.

Ms. Katsarov also provided an update on efforts to support ABA providers with the new Medi-Cal enrollment requirements and attended a vendor service meeting to address initial questions and concerns, particularly about difficulties with the state's website. She also noted that CalOptima Health had accelerated its quarterly ABA provider webinar to June and sent out notifications to ensure providers were aware of the new requirements and the importance of meeting the June 30, 2025 deadline. She emphasized the need for timely enrollment to avoid delays and ensure continued service provision. Additionally, she noted that PAC member Dr. Lorry Leigh Belhumeur of Western Youth Services, would also be hosting sessions on compassion fatigue for provider groups, and various resources would be made available to support those working in behavioral health.

Ms. Lee, also presented on the "Voice of the Member" program, which collects and analyzes member feedback to improve access to care. This program identifies issues members face, such as difficulties with authorizations and finding specialists. She noted that feedback is used to enhance outreach, support programs, and streamline processes like removing prior authorizations for certain screenings and quality improvement teams implementing these changes which will be monitored on a bi-weekly basis.

At the request of the MAC Chair Christine Tolbert, Cheryl Simmons, Program Manager and Staff to the Advisory Committees provided a brief overview of the new DHCS All-Plan Letter (APL) 25-009. The APL 25-009 summarizes the Community Advisory Committee’s (also known as the MAC at CalOptima Health) requirements and provides CalOptima Health with information and guidance regarding their responsibility to implement, maintain, and maximize member, family, and community engagement through the MAC. The MAC and the PAC both formed ad hoc committees at this meeting in order to review the seats on each committee to ensure compliance with APL 25-009, which requires that certain types of seats be added to the MAC.

Yunkyung Kim, Chief Operating Officer, noted that there had been no significant changes in membership or eligibility for Medi-Cal at this time and noted the importance of Social Services completing the redetermination on time and for members not to forego care due to fears about potential changes. Ms. Kim also clarified that CalOptima Health does not share immigration data with providers, ensuring patient privacy.

Veronica Carpenter, Chief Administrative Officer, provided an update on Covered California and the fiscal year 2025-2026 budget. She discussed how the board approved the initial investment needed for Covered California and the filing with the Department of Managed Health Care (DMHC). She discussed the filing process and noted feedback was expected from DMHC before final submission in February 2026 and noted that the budget included $14.5 million for Covered California, with $4 million already approved for consultant fees.

Ms. Carpenter also discussed legislative updates, including opposition to the proposed cuts and changes to the medical loss ratio. She noted that the California legislature was expected to pass the budget by June 15, with potential amendments to be added later in the year. She also noted that the key proposals included modifying asset limits, adjusting premiums for undocumented members, and establishing a re-enrollment grace period. On the Federal side, the Senate finance committee was expected to release language in the near future and any changes would need to go back to the House for approval. Ms. Carpenter emphasized the ongoing advocacy efforts and the importance of engaging with local representatives.

Richard Pitts, D.O., Ph.D., Chief Medical Officer, reminded the committees that if they have cold symptoms to please take a COVID test as there had been a COVID resurgence in Orange and Los Angeles counties.

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

REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

June 5, 2025

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on June 5, 2025, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person, and at the teleconference location: Association of California Water Agencies, 980 9th Street, Suite 1000 Sacramento, CA 95814, which was accessible to members of the public and via Zoom webinar as allowed for under Assembly Bill 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under View Past Meeting Materials. Chair Isabel Becerra called the meeting to order at 2:04 p.m., and Director Maura Byron led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair; Supervisor Vicente Sarmiento, Vice Chair; Maura Byron; Supervisor Doug Chaffee (left meeting at 5:20 p.m.); Blair Contratto; Norma García Guillén; Catherine Green, R.N.; Brian Helleland; Jose Mayorga, M.D. (left meeting at 5:10 p.m.)

(All Board members participated in person, except Catherine Green, R.N., who participated remotely under the traditional Brown Act rules and Jose Mayorga, M.D., who participated remotely under Just Cause, using his first of two uses for Calendar Year 2025)

Members Absent: Veronica Kelley (non-voting)

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

The Clerk noted for the record that staff would like to pull Agenda Item 17 for a separate vote due to a recusal. The Clerk also noted that staff would like to reorder the agenda to hear Agenda Items 26, 28 and 30, immediately after Agenda Item 25, and then hear Agenda Items 27, 29 and 31. In addition, staff would like to adjourn to Closed Session prior to hearing Agenda Items 32 and 33.

PRESENTATIONS/INTRODUCTIONS

None.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

Michael Hunn, Chief Executive Officer, presented his report and started by welcoming everyone, including those individuals that are listening to the meeting remotely.

Mr. Hunn briefly reviewed the Fast Facts, noting that CalOptima Health currently serves approximately 901,899 individuals. He reported that CalOptima Health's Key Financial Indicators, which are: operating income/(loss); non-operating income/(loss); bottom line (change in net assets); Medical Loss Ratio

(MLR); and Administrative Loss Ratio (ALR), are all showing green, meaning they are within budget.

CalOptima Health's Board-designated reserves are a little over $1.5 billion; its statutory designated reserves are $131.6 million; its capital assets are $100.3 million; its unspent balance of allocated resources committed by the Board are $437.6 million; its unspent balance of Board-approved provider rate increases are $350.8 million; and its unallocated resources are $130.0 million. Mr. Hunn noted that CalOptima Health's total net assets are currently $2.7 billion.

Mr. Hunn also added that the usual information in the Fast Facts – the personnel summary, provider network data, treatment authorizations, and member demographics – are in the meeting materials. He thanked all the staff who helped to prepare the Fast Facts report, which allows the Board and the public to see CalOptima Health's overall performance.

Mr. Hunn asked Yunkyung Kim, Chief Operating Officer, to give a brief update on the Community Based Adult Services (CBAS), which was requested by the Board at its last meeting.

Ms. Kim noted that this is in follow-up to the actions that the CalOptima Health Board approved regarding waiving overpayments in an amount up to $4.5 million to CBAS providers as a result of an error made by the Department of Health Care Services (DHCS) in its published fee schedule. The Board directed staff to find out how CalOptima Health's CBAS providers spent the overpayments during impacted timeframe. Ms. Kim reported that staff reviewed the financial statements of facilities that totaled about 80% of CalOptima Health's calendar year 2024 CBAS provider payments. She noted that out of 49 facilities, staff reviewed financials for about 19 facilities, which represented 80% of the payments made during that timeframe. Ms. Kim added that staff did receive financials from other CBAS providers, but the sample was too small and therefore not included. In aggregate, CalOptima Health CBAS providers used 96% of the overpayments received on member care. The amount of the overpayment spread over CalOptima Health's CBAS providers amounted to about 10%, so its providers would have experienced a net loss if the Board had not approved waiving the overpayments.

Mr. Hunn thanked Ms. Kim for the follow-up on the CBAS payments and reported on a few additional items from his report.

Mr. Hunn reported that on May 21, 2025, CalOptima Health celebrated Cal State Fullerton's first cohort of Master of Social Work stipend recipients graduated. Through CalOptima Health's workforce development funding, 22 new social workers received a $20,000 stipend each year during the two-year program in exchange for their commitment to work at least two years in Orange County's health care safety net serving Medi-Cal members. Two of those 22 students were recognized. One was honored with an Outstanding Graduate Student Award, and the other was honored with an Outstanding Research Award. Mr. Hunn noted that CalOptima Health's investment was about $5 million dollars in this program, and now its members will be served in a host of programs and care settings where social workers provide services. He thanked the Board for approving this investment, thanked Director Chaffee for his work in championing this pilot program, and congratulated the 22 students who have graduated.

Mr. Hunn also reported that CalOptima Health collaborated with Northgate Gonzalez Market and Alina Imaging to host a mobile mammogram event on May 30, 2025, at the Northgate Market in Anaheim. The event provided access to care for CalOptima Health Community Network members while supporting CalOptima Health's HEDIS and quality measures. Mr. Hunn noted the importance of early screening for breast cancer and how hosting mobile mammograms out in the community is a great way to encourage

members to get screened.

Mr. Hunn reported that CalOptima Health's Street Medicine Program in Garden Grove recently marked its two-year anniversary, celebrating success in delivering health care directly to its most vulnerable members. He added the Street Medicine Program has helped more than 600 individuals with primary care and social services, demonstrating CalOptima Health's commitment to providing accessible health care. Mr. Hunn thanked CalOptima Health's partners in the Garden Grove Street Medicine Program – Health Care in Action, the Garden Grove City Council, the fire and police chiefs, the city manager, community outreach workers, and the street medicine team at CalOptima Health.

PUBLIC COMMENTS

- Jewel Loff, Coalition of Orange County Community Health Centers: Oral report regarding the MATConnect Grant, Agenda Item 30.
- Georgina Maldonado, Community Health Initiative of Orange County: Oral report regarding revisions to CalOptima Health Policy AA.1400: Grants Management, Agenda Item 27.

CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the May 1, 2025 Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the February 20, 2025 Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee

3. Approve New CalOptima Health Policy IT.1002: Artificial Intelligence and Machine Learning

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

5. Adopt Resolution No. 25-0605-01 Authorizing and Directing Execution of Contract MS-2526-41 with the California Department of Aging for the Multipurpose Senior Services Program

6. Adopt Resolution No. 25-0605-02 Approving Updated CalOptima Health Human Resources Policies

7. Approve New CalOptima Health Policy EE.1104: Skilled Nursing Facility Workforce and Quality Incentive Program

8. Approve New CalOptima Policy EE.1146: Provider Directory

9. Approve New CalOptima Health Policy MA.6045: Special Supplemental Benefits for the Chronically Ill

10. Approve New CalOptima Health Policy GG.1669: Complex Cancer Care

11. Approve New CalOptima Health Clinical Policies in Accordance with Covered California Regulatory Requirements for the Department of Managed Health Care Filing

Back to Agenda

12. Approve New CalOptima Health Policy CC.1100: Oversight of Administrative Vendors in Accordance with Covered California Regulatory Requirements for the Department of Managed Health Care Filing

13. Approve New CalOptima Health Operations Policies in Accordance with Covered California Regulatory Requirements for the Department of Managed Health Care

14. Approve New CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access in Accordance with Covered California Regulatory Requirements for the Department of Managed Health Care Filing

15. Approve New CalOptima Health Policy CC.2000: Emergency Declaration in Accordance with Covered California Regulatory Requirements for the Department of Managed Health Care Filing

16. Approve New CalOptima Health Policy GG.1705: Community Reinvestment

17. Authorize a License Agreement with the County of Orange for Use of Space at the County Community Service Center
This item was pulled from the Consent Calendar due to a recusal and was heard separately.

18. Authorize Actions Related to the Student Behavioral Health Incentive Program Funding Strategy

19. Receive and File:
a. April 2025 Financial Summary
b. Compliance Report
c. Government Affairs Reports
d. CalOptima Health Community Outreach and Program Summary
e. Board Approved Initiatives Quarter Three Fiscal Year 2025 Impact Summary

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 2 through 19, minus Agenda Item 17, as presented. (Motion carried 9-0-0; Director Kelley (non-voting) absent)***

CONSENT CALENDAR

17. Authorize a License Agreement with the County of Orange for Use of Space at the County Community Service Center
Vice Chair Sarmiento did not participate in this item due to his role as Supervisor at the County of Orange and left the room during the discussion and vote.

Supervisor Chaffee noted that the County is trying to consolidate its offices to assist its constituents and many of those individuals would be CalOptima Health members.

Ms. Kim responded to Board members' questions and comments.

Back to Agenda

Director Garcia Guillen directed staff to monitor how many new members are being enrolled and how many members are being served through the County Community Service Center in Brea and report back to the Board on the outcomes of those metrics going forward.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer, with the assistance of legal counsel, to negotiate and execute the License Agreement with the County of Orange for a ten-year term beginning July 1, 2025, at the County Community Service Center, located at 675 Placentia Avenue, Suite 100, Brea, California, 92821; and 2.) Approved allocation of up to $135,500 from existing reserves to fund the License Agreement, a fulltime bilingual Spanish speaking Customer Service Representative, and general administrative costs for the period of July 1, 2025, through June 30, 2026. (Motion carried 8-0-0; Vice Chair Sarmiento recused; Director Kelley (non-voting) absent)***

REPORTS/DISCUSSION ITEMS

20. Approve the CalOptima Health Fiscal Year 2025-26 Operating Budget

Nancy Huang, Chief Financial Officer, presented the Fiscal Year (FY) 2025-26 Operating Budget for CalOptima Health. She noted that she would be focusing on the main components of the budget and added that there is a lot that CalOptima does not know at the state and federal levels. Ms. Huang added that the Finance and Audit Committee (FAC) met on May 22, 2025, and had robust discussions and noted, for other Board members and for members of the public, that the recording of that meeting is available on CalOptima Health's website.

Mr. Hunn provided opening comments on the FY 2025-26 Operating Budget, noting that with all the uncertainty regarding budget cuts at the state and federal levels, it is likely that staff will need to bring revisions to CalOptima Health's FY 2025-26 Operating Budget back to the Board in the future.

Ms. Huang thanked Mr. Hunn for his comments and reviewed the details of FY 2025-26 Operating Budget noting that CalOptima Health is proposing a $4.7 billion budget for the next fiscal year, with an average enrollment forecast of 885,000. The estimated revenue is $4.7 billion, with approximately 93.3% ($4.38 billion) allocated to medical-related expenses. The administrative budget request is $279 million, and the ALR is estimated at 5.95%. The operating margin, calculated as total revenue minus medical costs and administrative expenses, is about $32 million, which is 0.7%.

In a budget-to-budget comparison between FY 2024-25 and FY 2025-26, the average monthly enrollment is expected to decrease by about 16,000 lives (2%), based on historical enrollment trends. Revenue is projected to be $400 million (9%) higher than the current year's budget, driven by higher-than-anticipated draft rates for calendar year 2025 and changes in member mix forecasted for FY 2025-26. Medical costs are forecasted to increase by 3% ($126 million), primarily due to cost trends, increased utilization, and an aging membership population. The administrative expense budget is expected to increase by $27 million, primarily due to salary and benefit-related items, including normal merit increases and higher employee healthcare benefits. Additionally, non-salary-related administrative expenses are projected to rise by $14 million, driven mainly by IT-related projects and digital transformation initiatives.

Back to Agenda

Ms. Huang added that CalOptima Health's MLR is projected to be 93.35%, and the ALR is projected to be 5.95% for FY 2025-26.

Ms. Huang and Mr. Hunn responded to Board members' questions and comments.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Approved the CalOptima Health Fiscal Year 2025-26 Operating Budget and Non-Operating Items and authorized expenditures and appropriated funds for the items in Attachment A: Fiscal Year 2025-26 Operating Budget for All Lines of Business and Non-Operating Items and Attachment B: Administrative Budget Details; 2.) Approved the CalOptima Health Fiscal Year 2025-26 Covered California Budget, allocated up to $10.8 million from existing reserves to fund pre-implementation expenditures related to Covered California, and authorized expenditures and appropriated funds for the items in Attachment B1: Covered California Administrative Budget Details; and 3.) Approved the CalOptima Health Fiscal Year 2025-26 Digital Transformation Strategy Budget and authorized expenditures and appropriated funds for the items in Attachment B2: Digital Transformation Administrative Budget Details. (Motion carried 9-0-0; Director Kelley (non-voting) absent)***

21. Approve the CalOptima Health Fiscal Year 2025-26 Routine Capital, Covered California, and Digital Transformation Year Four Capital Budgets

Ms. Huang presented the capital budget proposal for FY 2025-26, which included three major components: routine capital items, projects to support Covered California implementation, and a digital transformation strategy update. The routine capital budget request for the next fiscal year is $28.5 million. Additionally, CalOptima Health is requesting $3.7 million for Covered California, bringing the total new capital request to $32.3 million. The digital transformation capital budget has already been funded by a $100 million reserve, so no additional funding is requested for that.

The routine capital budget of $28.5 million is primarily allocated to support information technology-related projects, which account for 61% ($17.3 million) of the total routine capital budget. These projects include infrastructure, application management, enterprise data, and system integration. Additionally, $11.2 million is requested for building and office improvements, which include $4.7 million for the 505 building, $4.8 million for the 500 building, $1.3 million for the PACE Center, and $0.25 million for the Street Medicine Support Center. These improvements are essential to support CalOptima Health's current and newly acquired office buildings and ensure the smooth operation of its services.

Combining the four categories, the total capital budget request is $32.3 million, with detailed project information included in the attachment. Following the routine capital, an additional $3.7 million is requested to support Covered California. This includes $885,000 for core system configuration to integrate data and processes and $1.4 million for enterprise data and system integration to ensure seamless enrollment, regulatory compliance, file transactions, and reporting. Additionally, $1.5 million is allocated for the development of an online billing and premium collection platform, with plans to initiate an RFP process after the fiscal year begins.

Back to Agenda

In summary, the total capital project cost for Covered California in FY 2025-26 is $3.7 million. Combining this with the operating budget, the total investment for the new lines of business next year is $14.5 million. Some projects had already been allocated $4.75 million by the Board in December 2024, covering gap analysis, actuarial services, and legal support. For the digital transformation strategy, the Board suggested a roadmap starting from FY 2022-23 through FY 2025-26, with a request for a two-year extension to complete existing projects. The digital transformation costs are expected to decrease from $30 million to $17 million, and eventually to $300,000, as expenses transition to normal operations. The $100 million allocation remains unchanged, detailing how resources will be spent over the next two years.

The digital transformation strategy includes projects like the member portal, provider portal, and human resources support system infrastructure. The budget allocation from year one through year five outlines major deliverables and returns on these investments.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Approved the CalOptima Health Fiscal Year 2025-26 Routine Capital Budget and authorized expenditures and appropriated funds for the items in Attachment A: Fiscal Year 2025-26 Routine Capital Budget by Project; 2.) Approved the CalOptima Health Fiscal Year 2025-26 Covered California Capital Budget, allocated up to $3.72 million from existing reserves to fund pre-implementation expenditures related to Covered California, and authorized expenditures and appropriated funds for the items in Attachment A1: Fiscal Year 2025-26 Covered California Capital Budget by Project; and 3.) Approved the CalOptima Health Fiscal Year 2025-26 Digital Transformation Year Four Capital Budget, extended the Digital Transformation Strategy for two years, through June 30, 2027, to complete ongoing and new projects, and authorized expenditures and appropriated funds for the items in Attachment A2: Update to Digital Transformation Years One through Three and Year Four Capital Budgets by Project. (Motion carried 9-0-0; Director Kelley (non-voting) absent)***

22. Approve Actions Related to Knox-Keene Act Licensure Filing to the Department of Managed Health Care for Covered California Participation

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors authorized the Chief Executive Officer to initiate, submit, and complete a filing with the Department of Managed Health Care to expand CalOptima Health's current Knox-Keene Act license to operate a Covered California health plan. (Motion carried 9-0-0; Director Kelley (non-voting) absent)***

23. Authorize Actions Related to the Board Approved Initiatives Reserve Fund and Intergovernmental Transfer-Funded Initiatives

Action: ***On motion of Vice Chair Sarmiento, seconded and carried, the Board of Directors: 1.) Authorized closing the following Board-approved initiatives and transferring the remaining funds of $23,964,513, in***

aggregate, to unallocated reserves: a.) Calendar Year 2023 OneCare Member Health Rewards and Incentives; b.) Temporary, short-term Public Health Emergency transition supplemental Medi-Cal rate increases; and c.) Proposed Community Living and PACE Center in the City of Tustin; 2.) Authorized closing Board-approved Intergovernmental Transfers 1, 3, 5, 6, and 7 initiatives, as listed in Table 1, and designate the remaining balance of $848,924 as available for allocation to deliver enhanced services for Medi-Cal members; and 3.) Authorized closing Board-approved Intergovernmental Transfers 8, 9, and 10 initiatives, as listed in Table 2, and transfer the remaining funds of $9,037,981 to unallocated reserves to deliver covered services for Medi-Cal members. (Motion carried 9-0-0; Director Kelley (non-voting) absent)

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

Director Mayorga did not participate in this item due to his role as Chief Quality Officer and Senior VP at AltaMed Health Services and was muted and off camera during the discussion and vote.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors authorized the Chief Executive Officer, or designee, to execute amendments to the CalOptima Health Shared-Risk Group, Physician-Hospital Consortia, and Health Maintenance Organization Contracts, effective July 1, 2025, to delegate responsibility of certain Medi-Cal wraparound services, such as durable medical equipment/supplies, hospice, incontinence supplies, and non-emergency medical transportation, for OneCare members to the Health Networks and update payment terms. (Motion carried 8-0-0; Director Mayorga recused; Director Kelley (non-voting) absent)***

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

Director Garcia Guillen did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Director Helleland did not participate in this item due to his role as Chief Executive at Providence/St. Joseph Hospital and left the room during the discussion and vote.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: Authorized the Chief Executive Officer, or designee, to execute amendments to the CalOptima Health Medi-Cal Fee-for-Service Hospital Services Contracts, effective July 1, 2025, to update: 1.) Definition for Prior Authorization; 2.) Definition for UM Program; 3.) Language regarding determination of medically necessary covered services; and 4.) Language related to assignment, assumption, and change of control. (Motion carried 7-0-0; Director Garcia Guillen and Director Helleland recused; Director Kelley (non-voting) absent)***

Back to Agenda

Note: Troy Szabo, Outside General Counsel, Kennaday Leavitt, noted for the record after Agenda Item 31 was read that there was not an in-person quorum at the meeting location at the time of the vote for Agenda Item 25 and therefore this item was also continued.

As the clerk noted at the top of the agenda, staff reordered the agenda to hear Agenda Items 26, 28 and 30 immediately after Agenda 25.

Chair Becerra noted for the record that she is recusing herself on Agenda Items 26, 28 and 30 due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and would leave the room during the discussion and vote. Chair Becerra passed the gavel to Vice Chair Sarmiento and left the room.

26. Authorize Funding of Provider Stipends for Attending CalOptima Health Excellence in Care Educational Events

Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and left the room during the discussion and vote. Director Mayorga did not participate in this item due to his role as Chief Quality Officer and Senior VP at AltaMed Health Services and was muted and off camera during the discussion and vote.

Action: ***On motion of Director Helleland, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer or their designee to offer stipends, up to $200, to participating providers for attending Excellence in Care educational events during the period of June 5, 2025, through June 30, 2026, in order to improve Medicare Star Ratings; and 2.) Approved the use of Measurement Year 2023 unearned Pay for Value funds for stipend costs in an amount not to exceed $150,000. (Motion carried 7-0-0; Chair Becerra and Director Mayorga recused; Director Kelley (non-voting) absent)***

28. Authorize Amendments to the Grant Agreements with CalOptima Health Comprehensive Community Cancer Screening and Support Grantees

Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and left the room during the discussion and vote. Director Garcia Guillen did not participate due to potential conflicts of interest and left the room during the discussion and vote. Director Mayorga did not participate in this item due to his role as Chief Quality Officer and Senior VP at AltaMed Health Services and was muted and off camera during the discussion and vote.

This item was continued due to lack of an in-person quorum at the meeting location.

30. Authorize the Closing of the Grant Agreement with the Coalition of Orange County Community Health Centers to Increase Access to Medication-Assisted Treatment

Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and left the room during the discussion and vote. Director Mayorga did not participate in this item due to his role as Chief Quality Officer and Senior VP at AltaMed Health Services and was muted and off camera during the discussion and vote.

The Board heard public comment on this item as indicated under the Public Comment section.

Back to Agenda

After considerable discussion on this item, staff suggested continuing this item to allow for review of the final report on this grant agreement to increase access to medication-assisted treatment and bring back a recommendation to a future Board meeting.

Action: ***On motion of Vice Chair Sarmiento, seconded and carried, the Board of Directors approved continuing this item to allow for review of the final report on this grant agreement and bring back a recommendation to a future Board meeting. (Motion carried 6-1-0; Chair Becerra and Director Mayorga recused; Vice Chair Sarmiento, Directors Byron, Contratto, Garcia Guillen, Green and Helland voting yes, Supervisor Chaffee voting no; Director Kelley (non-voting) absent)***

27. Approve Actions Related to CalOptima Health Policy AA.1400: Grant Management
The Board heard public comment on this item as indicated under the Public Comment section.

Supervisor Chaffee noted that he was opposed to the changes in Policy AA.1400 regarding limiting a grantee's ability to apply for another grant if they currently have a grant agreement with CalOptima Health. He noted that he wants the best agencies to be able to apply for the grants and not limit them because they currently have a grant in process, provided they are in good standing and all other requirements are met.

After a robust discussion, the Board asked to continue to this item to allow time for the review of the consultant's report on potential changes to the grant management policy.

Action: ***On motion of Director Mayorga, seconded and carried, the Board of Directors approved continuing this item to allow for review of consultant's report on changes to the grant management policy and bring policy back to a future Board meeting. (Motion carried 9-0-0; Director Kelley (non-voting) absent)***

29. Approve Actions Related to the Housing and Homelessness Incentive Program
The clerk noted for the record that Agenda Item 29 had the incorrect date of May 1, 2025, on the CalOptima Health Board Action Agenda Referral (COBAR), which will be corrected in the archived materials.

Action: ***On motion of Vice Chair Sarmiento, seconded and carried, the Board of Directors approved CalOptima Health staff recommendations to administer grant agreements and award payments totaling $200,000 for equity grants and $2.5 million for systems change grant recipients (Attachment 1) related to the Housing and Homelessness Incentive Program. (Motion carried 9-0-0; Director Kelley (non-voting) absent)***

31. Authorize Extension of Grant Award Agreement with Mind OC for the Be Well OC Irvine Campus
Director Contratto did not participate in this item due to her role as Chief Strategy Officer at Be Well OC and left the room during the discussion and vote. Director Helleland did not participate in this item due to his role as Chief Executive at Providence/St. Joseph Hospital and left the room during the discussion and vote.

Back to Agenda

Troy Szabo, CalOptima Health's Outside General Counsel, noted that due to recusals and remote participation, this item would need to be continued due to a lack of an in-person quorum at the meeting location. Mr. Szabo also noted that for Agenda Item 25, there was not an in-person quorum at the meeting location and as such Agenda Item 25 would need to be continued.

As the clerk noted at the top of the meeting, the agenda was reordered to hear Closed Session prior to hearing Agenda Items 32 and 33.

CLOSED SESSION

The Board adjourned to Closed Session at 4:25 p.m. Pursuant to Government Code section 54956.87, subdivision (b) HEALTH PLAN TRADE SECRETS: Covered California and CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Government Code section 54956.9(d)(2): 3 Cases.

The Board returned to Open Session at 5:50 p.m., and the Clerk re-established a quorum.

ROLL CALL

Members Present: Isabel Becerra, Chair; Supervisor Vicente Sarmiento, Vice Chair; Maura Byron; Supervisor Doug Chaffee (left meeting at 5:20 p.m.); Blair Contratto; Norma García Guillén; Catherine Green, R.N.; Brian Helleland; Jose Mayorga, M.D. (left meeting at 5:10 p.m.)

(All Board members participated in person, except Catherine Green, R.N., who participated remotely under the traditional Brown Act rules and Jose Mayorga, M.D., who participated remotely under Just Cause, using his first of two uses for Calendar Year 2025)

Members Absent: Veronica Kelley (non-voting)

CLOSED SESSION

Chair Becerra noted for the record that there were no reportable actions taken in Closed Session.

REPORTS/DISCUSSION ITEMS

32. Approve Actions Related to Contracts for Legal Services

Action: ***On motion of Director Byron, seconded and carried, the Board of Directors: 1.) Ratified a contract with Bird, Marella, Rhow, Lincenberg, Drooks, & Nessim, LLP for legal services effective September 16, 2024, and ratified an amendment to that contract effective May 30, 2025, through December 31, 2025; and 2.) Ratified a contract with Liebert Cassidy Whitmore, PC, to provide legal services effective May 12, 2025, through December 31, 2025. (Motion carried 7-0-0; Supervisor Chaffee and Director Mayorga absent)***

Back to Agenda

33. Authorize Unbudgeted Expenditures and Appropriate Funds for Legal Services

Action: ***On motion of Director Garcia Guillen, seconded and carried, the Board of Directors authorized unbudgeted operating expenditures and appropriated funds in an amount up to $2.1 million from existing reserves to fund legal services through December 31, 2025. (Motion carried 7-0-0; Supervisor Chaffee and Director Mayorga absent)***

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Director Contratto thanked staff for their exceptional work and detailed reports. She also appreciated the closeout efforts that brought funds back into the reserves to benefit CalOptima Health members.

Director Helleland thanked Ms. Huang for the work that went into this fiscal year's budget.

Chair Becerra echoed her colleagues' appreciation for the hard work on reporting and presentations, expressing gratitude for these efforts. She added that despite the heavy workload, she remains confident that CalOptima Health is in the right place, at the right time, making a positive impact on the community and the members that need it most.

ADJOURNMENT

Hearing no further business, Chair Becerra adjourned the meeting at 5:54 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: August 7, 2025

Back to Agenda

MINUTES

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

CALOPTIMA HEALTH
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

March 12, 2025

A Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee (Committee) was held on March 12, 2025, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under Past Meeting Materials.

Chair Jose Mayorga called the meeting to order at 3:02 p.m., and Director Catherine Green led the Pledge of Allegiance.

CALL TO ORDER

Members Present: Jose Mayorga, M.D. Chair; Maura Byron; Catherine Green, R.N.

(All Committee members in attendance participated in person.)

Members Absent: None.

Others Present: Yunkyung Kim, Chief Operating Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Troy Szabo, Outside General Counsel, Kennaday Leavitt; Kelly Giardina, Executive Director, Clinical Operations; Ladan Khamseh, Executive Director, Operations; Linda Lee, Executive Director, Quality Improvement; Donna Frisch, Medical Director, PACE; Sharon Dwiers, Clerk of the Board

ADVISORY COMMITTEE UPDATES

1. Program of All-Inclusive Care for the Elderly (PACE) Member Advisory Committee Update

Monica Macias Garcia, Director, CalOptima Health PACE, provided a brief overview of the PACE Member Advisory Committee (MAC) activities. Ms. Macias Garcia noted that the main topic of interest as of late has been the transportation issues. She noted that issues with transportation for PACE members have greatly improved. Ms. Macias Garcia noted that in her presentation to the Committee on December 11, 2024, there were 140 transportation violations in the past month and but today the number of transportation violations is 5 in the past month. Ms. Macias Garcia also noted that many of the violations are for pickup and drop-off times. She added that many PACE members are elderly and cannot be dropped off if no one is at the residence when the member arrives back home, so the driver will keep the member with them until someone is at the residence to accept the member. These types of circumstances lead to violations of timely drop-offs, which are not necessarily the transportation vendor's fault. Ms. Macias Garcia reported that staff and the PACE

members are happy that the issues around transportation are improving and that PACE is hiring a new transportation manager who will assist in scheduling PACE members' transportation needs. She noted that PACE members are expressing gratitude for the improvements related to transportation and the care they receive and staff at CalOptima Health's PACE facility.

Chair Mayorga had questions regarding ongoing comments about the transportation vendor.

PUBLIC COMMENTS
There were no public comments.

CONSENT CALENDAR
2. Approve the Minutes of the December 11, 2024, Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

Action: ***On motion of Director Green, seconded and carried, the Committee approved the Consent Calendar as presented. (Motion carried 3-0-0)***

REPORTS/DISCUSSION ITEMS
3. Recommend that the Board of Directors Receive and File 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program Evaluation and Recommend the Board of Directors Approve the 2025 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan
Linda Lee, Executive Director, Quality Improvement, provided a high-level overview of the evaluation of the 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program (QIHETP). Ms. Lee noted that the QIHETP is reviewed, evaluated, and approved annually by the Board of Directors. The QIHETP defines the structure within which quality improvement and health equity activities are conducted and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima Health members.

Ms. Lee reviewed in detail the achievements that CalOptima Health had in 2024, which included $25 million in workforce education grants and a $526 million investment to increase provider rates. She discussed the success of the Back to School Health and Wellness Fair, the launch of the second Street Medicine program, and the opening of the nation's first recuperative care center. Additional achievements for 2024 included the Quality Improvement Health Equity Committee (QIHEC) meeting 12 times in 2024, with six subcommittees meeting quarterly, and the launch of a new Population Health Management Committee. She added that CalOptima Health developed, approved, and implemented a new Culturally and Linguistically Appropriate Services (CLAS) Program, launched activities to prepare for the NCQA Health Equity Accreditation Survey (which is scheduled for October 7, 2025), and launched a Star Executive Steering Committee to focus on the Centers for Medicare & Medicaid Services Stars measure improvement.

Ms. Lee reviewed the 2024 priorities and goals, which included closing racial and ethnic disparities in well-child visits and maternity care for Black and Native American persons, exceeding the 50th percentile for all children's preventive care measures, improve maternal and adolescent depression screening by 50%, improving follow-up care for mental health and, substance abuse disorder by 50%, for Medi-Cal: exceed the minimum performance levels (MPLs) for Medi-Cal Managed Care Accountability Set (MCAS), and for OneCare: attain a Four-Star Rating for Medicare.

She reported which goals were met and also the goals where there were opportunities for improvement. For example, in the MCAS the goal is to reach the 50th percentile, CalOptima Health met 16 of the 18 MCAS held to the MPL. The two measures that did not meet the MPL were: Follow-up After ED visit for Alcohol and Other Drug Dependence within 30 days, and Follow-up After ED visit for Mental Illness within 30 days. Ms. Lee provided detailed information for the various measures and goals, noting that the 2024 evaluation results are used to determine strategies and areas to focus on in CalOptima Health's 2025 QEHITP.

Ms. Lee introduced the 2025 QEHITP, outlining changes, additions, and deletions from the program. She reviewed the program goals, which include closing racial and ethnic disparities, improving maternity care, and exceeding the 50th percentile for children's preventive care measures. Ms. Lee highlighted the addition of the new Population Health Management Committee and the expansion of the Comprehensive Community Cancer Screening Program. She added that the 2025 QEHITP also includes the implementation of a Diversity, Equity and Inclusion (DEI) Training Program and the identification and leveraging of technology and automation to streamline quality operations.

Katie Balderas, Director, Equity and Community Health, presented on the 2025 Population Health Management Strategy and Work Plan, noting that it is part of the QEHITP.

Ladan Khamseh, Executive Director, Operations, presented the 2024 Culturally and Linguistic Appropriate Services (CLAS) evaluation, highlighting the successful implementation of five of six work plan goals. The program includes updates to the member demographic data, language services, and training for staff and network providers.

Ms. Khamseh reported that the 2025 CLAS program will focus on expanding language services to include Russian and implementing DEI training for staff and network providers.

Staff responded to Committee members' comments and questions.

Action: ***On motion of Director Byron, seconded and carried, the Committee recommended that the Board of Directors: 1.) Receive and file the 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program (QIHETP) Evaluation; and 2.) Approve the 2025 CalOptima Health QIHETP and Work Plan. (Motion carried 3-0-0)***

4. Recommend that the Board of Directors Approve the 2024 CalOptima Health Utilization Management Program Evaluation and the 2025 CalOptima Health Integrated Utilization Management/Case Management Program Description

Kelly Giardina, Executive Director, Clinical Operations, presented the 2024 Utilization Management Program Evaluation, highlighting key accomplishments and program enhancements. Ms. Giardina noted that the program includes the enhancement of treatment authorization inventory oversight, facility rounds, and post-stabilization authorization process improvements. She noted that the program also includes the removal of preventative screening prior authorization requirements for OneCare and the transition of Kaiser members. Ms. Giardina noted that the program will continue to focus on under and overutilization, member satisfaction, and the promotion of health literacy and prevention.

Back to Agenda

Action: ***On motion of Director Green, seconded and carried, the Committee recommended that the Board of Directors: Approve the Annual 2024 CalOptima Health Utilization Management Program Evaluation, and Approve the updates to the Annual 2025 CalOptima Health Integrated Utilization Management and Case Management Program Description. (Motion carried 3-0-0)***

5. Recommend that the Board of Directors Receive and File 2024 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Work Plan Evaluation and Recommend the Board of Directors Approve the 2025 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Work Plan

Donna Frisch, M.D., PACE Medical Director, presented the 2024 accomplishments and goals for PACE. The program reached a milestone enrollment of 500 participants, distributed over 10,000 home-delivered meals, and achieved high influenza and pneumococcal vaccination rates. Dr. Frisch reported that the program set and exceeded goals for colorectal and breast cancer screenings and diabetes control, with 88% of participants achieving good control. She added that the program will focus on increasing vaccination rates, cancer screening, and blood pressure monitoring in 2025.

Action: ***On motion of Director Byron, seconded and carried, the Committee recommended that the Board of Directors: 1.) Receive and file the 2024 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Work Plan Evaluation, and 2.) Approve the 2025 Program of All-Inclusive Care for the Elderly Quality Improvement Work Plan. (Motion carried 3-0-0)***

INFORMATION ITEMS

6. 2024 Health Equity Report

Michaell Rose, Dr.PH, LCSW, presented the 2024 Health Equity Update, highlighting the commitment to health equity and the development of the community impact team. Dr. Rose noted that the team will focus on community-level impact, population-of-focus impact, and member-level impact, including health education classes and clinic days. Examples of community impact include participating in the Black History Parade and Cultural Event, which provided a wide range of health services. The team will continue to develop and implement strategies to close gaps in healthcare access and improve member satisfaction.

7. Quarterly Reports to the Quality Assurance Committee

a. Quality Improvement Health Equity Committee Report

Ms. Lee provided an update on the quarter four activities of the QIHEC. She noted that the committee reviewed the annual work plan, subcommittee reports, and quality oversight functions, including potential quality issues and credentialing of providers. Ms. Lee added the recommendations from the committee included a follow-up report from the Bright Steps program and an assessment of current immunization policies by primary care providers. She also reported that the committee monitored access and availability, member experience, and quality improvement policies and procedures.

Ms. Lee announced the approval of a new board certification entity for credentialing purposes in Canada, emphasizing the reciprocity between Canada and the United States. The Member

Experience Committee recommends continued peer-to-peer meetings between CalOptima Health Medical Directors and providers with repeated failures for timely access to care. CalOptima Health Medical Directors are conducting outreach to help providers understand requirements and obligations for timely access.

Ms. Lee noted that the Population Health Committee will be provide guidance to churches on engaging and connecting Orange County residents experiencing homelessness with resources.

b. Member Grievances and Appeals Report

Ms. Khamseh provided an overview of the fourth quarter grievances and appeals process, defining grievances as expressions of dissatisfaction and appeals as decisions made by the plan that members are unhappy with. Overall, there were 4437 grievances, and 387 appeals received during the fourth quarter for both lines of business, with a 9% decrease in grievances from the third to the fourth quarter. Ms. Khamseh noted that the grievances were mostly related to provider services, with no specific providers identified, and a 16% decrease in grievances for the One Care line of business. Appeals showed an increase for the Medi-Cal line of business from 328 to 346 in the fourth quarter, with a decrease in the overturned rate from 31% to 30%.

Ms. Khamseh presented a detailed breakdown of grievances and appeals, showing a slight decrease in grievances in the fourth quarter and compliance with the 30-day turnaround time. The rate per 1000 for each quarter is well below the NCQA recommendation, with a side-by-side comparison of Medi-Cal and OneCare grievances. Ms. Khamseh noted that the breakdown of grievances by health network shows CalOptima Health Community Network as one of the higher rates, with activities being discussed to address these issues. The top categories for grievances are quality of service, access to care, quality of care, and billing issues, with specific breakdowns for Medi-Cal and One Care.

Ms. Khamseh outlined actions taken to address grievances related to transportation, staff, and primary care physicians, including weekly meetings with vendors and an escalation process for critical appointments. She noted that the focus on dialysis patients is highlighted, with policies allowing multiple members to be transported together if they agree. Ms. Khamseh added that transportation issues for OneCare members using PAPA Pal services, such as no-shows and delays, are being addressed through coordination with the vendor and medical management. She also noted that an annual review of PAPA Pal services is planned, with Grievances and Appeals staff involved in assessing performance based on grievances received.

Ms. Khamseh reported on specialty care, noting that this refers to referrals to specialists and tertiary level of care. She added that complaints regarding specialty care arise from long wait times and inappropriate referrals.

Ms. Khamseh reported that complaints regarding durable medical equipment services mostly involve outpatient services, with providers referring to out-of-network labs for lab services.

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

c. Program of All-Inclusive Care for the Elderly Report
Ms. Macias noted that the topics for the quarterly PACE Report were covered earlier in the meeting.

COMMITTEE MEMBER COMMENTS
The Committee thanked staff for the depth of information and the ease of understanding the reports, highlighting the importance of transparency and communication.

ADJOURNMENT
Hearing no further business, Chair Mayorga adjourned the meeting at 4:54 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: June 18, 2025

Back to Agenda

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 7, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

4. Approve New Appointments and Reappointments to the CalOptima Health Whole-Child Model Family Advisory Committee

Contact

Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

Approve the Whole-Child Model Family Advisory Committee's recommendations as follows:

1. Reappoint the following individuals to each serve a two-year term on the Whole-Child Model Family Advisory Committee, effective upon Board of Directors approval:
    a. Cally Johnson as an Authorized Family Member Representative for a term ending June 30, 2027; and
    b. Lori Sato as an Authorized Family Member Representative for a term ending June 30, 2027.

2. Newly appoint the following individuals to each serve a two-year term on the Whole-Child Model Family Advisory Committee, effective upon Board of Directors approval:
    a. Fabiana Avendano as an Authorized Family Member Representative for a term ending June 30, 2026, fulfilling the existing term for the seat;
    b. April Johnston as an Authorized Family Member Representative for a term ending June 30, 2027;
    c. Mayra Ortiz as an Authorized Family Member Representative for a term ending June 30, 2027;
    d. Katya Aguilar as a Community Based Organization Representative for a term ending June 30, 2027; and
    e. Kristen Rogers as a Consumer Advocate Representative for a term ending June 30, 2027.

Background

Senate Bill 586 was signed into law on September 25, 2016, and authorized the establishment of the Whole-Child Model (WCM), incorporating California Children's Services (CCS)-covered services for Medi-Cal eligible children and youth into specified County-Organized Health System plans. A provision of the WCM program requires each participating health plan to establish a family advisory committee. Accordingly, the CalOptima Health Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC) by resolution on November 2, 2017, to report and

Back to Agenda

provide input and recommendations to the CalOptima Health Board relative to the WCM program.

The WCM FAC is comprised of 11 voting members, nine of whom are designated as Authorized Family Member Representatives and two of whom are designated as Community Based Organization/Consumer Advocate Representatives who represent the interests of children receiving CCS services. While two of the WCM FAC's 11 seats are designated as Community Based Organization/Consumer Advocate Representative seats, WCM FAC candidates representing the community may be considered for up to two additional WCM FAC seats if there are not enough Authorized Family Member Representative candidates to fill the nine designated seats.

Discussion

CalOptima Health conducted comprehensive outreach, including sending notifications to community-based organizations, conducting targeted community outreach to agencies and community-based organizations serving the various open positions, and posting recruitment materials on the CalOptima Health website and CalOptima Health's social media sites, such as LinkedIn and Facebook.

With the fiscal year ending on June 30, 2025, six WCM FAC seat terms will expire: four Authorized Family Member Representatives and two Community Based Organization/Consumer Advocate Representatives. One Authorized Family member seat with a term ending June 30, 2026, is also vacant.

The WCM FAC Nominations Ad Hoc Subcommittee, composed of WCM FAC members Vice Chair Erika Jewell, Jennifer Heavener, and Janis Price, evaluated each of the applicants for the current openings. The WCM FAC Nominations Ad Hoc Subcommittee proposes the slate of candidates for the seven vacancies and forwards the recommended slate of candidates for consideration at the June 18, 2025 Special Meeting of the Quality Assurance Committee for recommendation to and final appointment by the Board of Directors at its August 7, 2025, meeting.

The candidates for the seven open seats are as follows:

Authorized Family Member Representative

Cally Johnson (Reappointment)

Cally Johnson is the mother of a special needs child. Ms. Johnson has several years of experience working with the Autism Speaks foundation and as a long-term care ombudsman. Ms. Johnson has over 20 years of experience as a private tutor for children in grades K-12 with special needs. Ms. Johnson's knowledge of CCS places her in a unique perspective to assist families of children with special needs with her bilingual skills. She has been a member of the WCM FAC since 2023.

Back to Agenda

Lori Sato (Reappointment)
Lori Sato is the mother of a special needs child who currently receives CCS and Medi-Cal services. Ms. Sato has learned to navigate new systems to better advocate for children with special needs. She is familiar with medical therapy units for various therapies (physical and occupational) and for special equipment needs by CCS children. Ms. Sato has been inspired by other parents who are knowledgeable about the system to help CCS children get the care they need. She has been a member on the committee since July 2022, and she is the current Chair of the WCM FAC.

Fabiana Avendano (New Appointment)
Fabiana Avendano is the mother of a three-year old special needs child who has recently been accepted into the CCS program and who is a CalOptima Health Medi-Cal member. Ms. Avendano would like to participate in the WCM FAC in order to share her experiences and advocate on behalf of the special needs community. Ms. Avendano is the mother of two sons who has the will to move forward, inform, help and contribute to the success of the committee.

April Johnston (New Appointment)
April Johnston is the mother of a one-year-old special needs child who is enrolled in CalOptima Health Medi-Cal and is currently receiving CCS services. Ms. Johnston has many connections in the community and would like to learn how to better advocate on behalf of special needs children by learning about the various services that are offered in the community.

Mayra Ortiz (New Appointment)
Mayra Ortiz is the mother of a two-year-old, special needs daughter whose experience with CCS is just beginning as her daughter receives physical and occupational therapy at one of the CCS units due to several medical conditions. The care at the CCS unit has been a great help to her daughter's well-being. Ms. Ortiz would like to learn more about the CCS program and gain knowledge to be able to provide the best medical care for her daughter and other children as a responsible individual who is eager to learn.

Community-Based Organization Representative

Katya Aguilar (New Appointment)
Katya Aguilar is an Early Childhood Supervisor and Developmental Screening Coordinator for the Family Support Network where she oversees the Early Childhood department and coordinates developmental screenings for children ages 0-5. Ms. Aguilar helps families learn how to access CalOptima Health covered services by guiding and empowering families with the knowledge and tools they need to advocate for their child's care while collaborating with community partners to ensure they are connected to the appropriate resources and support systems.

Consumer Advocate Representative

Back to Agenda

Kristen Rogers (New Appointment)
Kristen Rogers is the mother of a special needs adult who received CCS services until March 2025 when her son aged out of CCS and is currently a CalOptima Medi-Cal member. Ms. Rogers is an active volunteer at Children's Health Orange County and has been a member in good standing of the WCM FAC since 2018. Ms. Rogers served on the CCS Advisory Group, where she represented CalOptima Health and the WCM FAC, from March 2019 until her son aged out of the CCS program. She also previously served as Chair of the WCM FAC.

Fiscal Impact
Each WCM FAC member may receive a stipend of up to $50 per committee meeting attended. Funding for the stipends is a budgeted item in the CalOptima Health Fiscal Year 2025-26 Operating Budget. Staff will also include the estimated cost in future operating budgets.

Rationale for Recommendation
As stated in policy AA.1271, the WCM FAC established a Nominations Ad Hoc Subcommittee to review the potential candidates for vacancies on the committee. The WCM FAC Nominations Ad Hoc Subcommittee forwards the recommended candidates to the Board of Directors' Quality Assurance Committee for consideration and recommendation to the Board of Directors.

Concurrence
Whole-Child Model Family Advisory Committee Nominations Ad Hoc Subcommittee
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s/ Michael Hunn *07/31/2025*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 7, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Approve Reappointments and Appointments to the CalOptima Health Board of Directors' Member Advisory and Provider Advisory Committees

Contact

Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1. Appoint the following individual to the Member Advisory Committee:
    a. Tawny Crane as the Foster Children Representative for a three-year term ending June 30, 2028.

2. Reappoint the following individuals to the Member Advisory Committee to each serve a three-year term ending June 30, 2028:
    a. Margie Moore as the Medi-Cal Beneficiaries or Authorized Family Member Representative;
    b. Sara Lee as the Member Advocate Representative; and
    c. Keiko Gamez as the OneCare Member or Authorized Family Member Representative.

3. Appoint the following individual to the Provider Advisory Committee:
    a. Nury Melara as an Allied Health Representative for a three-year term ending June 30, 2028.

4. Reappoint the following individuals to the Provider Advisory Committee to each serve a three-year term ending June 30, 2028:
    a. Patty Mouton as the Long-Term Services and Supports Representative;
    b. John Nishimoto, O.D., as the Non-Physician Medical Practitioner Representative;
    c. Mary Pham, Pharm.D., CAC, as the Pharmacy Representative; and
    d. Morgan Mandigo, M.D., as a Physician Representative.

Background

The CalOptima Health Board of Directors (Board) established the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) by resolution on February 14, 1995, to provide input to the Board. The MAC is comprised of seventeen voting members and the PAC is comprised of fifteen voting members. Pursuant to the resolution, MAC and PAC members serve three-year terms, except for one standing seat for the representative from the County of Orange Social Services Agency for MAC and a standing seat for the Orange County Health Care Agency for PAC. The Board is responsible for the appointment of all MAC and PAC members.

Discussion

CalOptima Health staff conducted comprehensive outreach, including sending notifications to community-based organizations (CBOs), conducting targeted community outreach to agencies and CBOs serving the various open positions on both the MAC and PAC, and posting recruitment materials on CalOptima Health's website and social media sites.

Back to Agenda

The MAC Nominations Ad Hoc Subcommittee, composed of MAC Chair Christine Tolbert, Vice Chair Meredith Chillemi, and committee member Dr. Junie Lazo-Pearson, evaluated each applicant and forwarded the proposed slate of candidates for the four vacancies to the MAC.

The PAC Nominations Ad Hoc Subcommittee, composed of PAC Vice Chair Gio Corzo and committee members Andrew Inglis, M.D., and Jena Jensen, evaluated each applicant and forwarded their recommendations to the PAC for the six vacancies on the PAC.

At the June 12, 2025, joint MAC and PAC meeting, each committee separately approved the recommended slate of candidates as proposed by the MAC and PAC Nominations Ad Hoc Subcommittees and requested that the proposed slate of candidates for each committee be forwarded to the Board for its consideration at the August 7, 2025, meeting. Staff will continue recruitment for the open OneCare Member or Authorized Family Members Representative on MAC and the Physician Representative on PAC until these seats are filled.

The recommended MAC candidates for the open positions are as follows:

Foster Children Representative
Tawny Crane – New Appointment
Ms. Crane is Senior Social Services Supervisor for the Orange County Social Services Agency (SSA). Ms. Crane has over 21 years of experience working directly and indirectly with Orange County dependents (foster children). Her experience includes advocating for their health care and working with CalOptima Health directly as needed. Currently, she is the Orange County SSA Children and Family Services Representative for the Managed Care Memorandum of Understanding that has been in development with CalOptima since late 2024. Ms. Crane holds a Bachelor of Arts in Psychology from Biola University and a Master of Arts in Marriage and Family Therapy from Chapman University.

Medi-Cal Beneficiaries or Authorized Family Member Representative
Margie Moore – Reappointment
Margie Moore is the mother of a special needs adult who has Medi-Cal through CalOptima Health. A realtor for over 20 years, she currently volunteers at various organizations for the special needs community. She has been on the MAC since 2024 where she fulfilled an existing term for a Medi-Cal Beneficiary or Authorized Family Member seat.

Member Advocate Representative
Sara Lee – Reappointment
Sara Lee is an attorney at Community Legal Aid SoCal, a partner of the statewide Health Consumer Alliance, where she is the supervising attorney of the Health Consumer Action Center unit. Ms. Lee is a former member of the OneCare Connect Member Advisory Committee (OCC MAC), where she served as the Ethnic and Cultural Community Representative and Ombudsman and advocated on behalf of CalOptima's OCC members until that program ended in December 2022. Ms. Lee has served on the MAC since 2022.

Back to Agenda

OneCare Member or Authorized Family Member Representative

Keiko Gamez – Reappointment

Ms. Gamez is a OneCare Member who is interested in serving others. She has experienced many difficulties in her life, but overcoming these experiences provides her with the opportunity to make valuable contributions to the committee. Ms. Gamez also wants to help others who experience difficulties accessing care. She describes herself as a problem solver with skills to resolve difficult tasks. Ms. Gamez is a former OCC MAC member who served on that committee for four years and was the committee vice chair for two years through December 31, 2022, when the program ended. She has been a member of the MAC since May 2023.

The recommended PAC candidates for open seats are as follows:

Allied Health Services Representative

Nury Melara – New Appointment

Ms. Melara is a union representative for United Domestic Workers. In that capacity, Ms. Melara works with In-Home Supportive Services providers that provide custodial care to CalOptima Health's eligible members. By working closely with the caregivers, she has gained an understanding of the needs of seniors and persons with disabilities.

Long-Term Services and Supports Representative

Patty Mouton – Reappointment

Patty Mouton has been the vice president of outreach and advocacy at Alzheimer's Orange County since 2005 and has worked in health care for older adults for over 20 years. She oversees professional and clinical activities and events, provides community education programs, and coordinates legislative advocacy and public policy-forming activities. In addition, she speaks to community groups about medical coverage issues and defines the continuum of care. Ms. Mouton is a past chair and former member of the MAC, having served until 2021. She holds a certificate in fundamentals of gerontology from the University of Southern California, a certificate in palliative care chaplaincy from California State University, San Marcos, and a Bachelor of Science in human services from Springfield College. She has served on the PAC since 2022.

Non-Physician Medical Practitioner Representative

The PAC received two applicants for this seat. John Nishimoto, O.D., and Jeremy Elkins. The PAC Nominations Ad Hoc Subcommittee is recommending the re-appointment of Dr. Nishimoto for this seat.

John Nishimoto, O.D. – Reappointment

Dr. Nishimoto is currently a professor and senior associate dean for Professional Affairs at Marshall B. Ketchum University and Southern California College of Optometry. He has active engagements with the leadership of the California Optometric Association (COA), the COA Health Care Delivery Systems Committee, and the leadership of the American Academy of Optometry and the California Academy of Physician Assistants. He is the chair for the Board of Integrated Health Care Solutions, which includes collaborative organizations such as Giving Children Hope and the Illumination Foundation. Dr. Nishimoto is currently serving a two-year term as the PAC Chair and has been a member of the PAC since 2016.

Back to Agenda

Pharmacy Representative

Mary Pham, Pharm.D., CHC – Reappointment

Dr. Pham previously served as the Pharmacy Representative on the PAC from 2014-2019. Dr. Pham is currently the chief executive officer and pharmacist in charge of AllCare Specialty Pharmacy in Santa Ana. Dr. Pham has over 22 years of pharmacy experience and has been a health care consultant for over 10 years, working with local clinics. Dr. Pham has also served for the past five years as a Health Resources and Services Administration government contractor for 340B Subject Matter Expertise.

Physician Representative

Morgan Mandigo, M.D. – Reappointment

Dr. Mandigo is an Obstetrician/Gynecologist with St. Jude Neighborhood Health Center where 80-90% of her patients are CalOptima Health members. Dr. Mandigo holds active medical licenses in seven states, including California. She is a member of the American College of Obstetricians and Gynecologists (ACOG) committee for underserved women and hopes to highlight statewide women's health initiatives that would benefit CalOptima Health patients. Dr. Mandigo also serves on the District IX Legislative Committee and is a member of ACOG's committee on Health Care for Underserved Women and Gender Diverse Individuals. Dr. Mandigo has served for one-year on the PAC as she was fulfilling an existing term.

Fiscal Impact

Each member or family representative serving on the MAC may receive a stipend of up to $50 per committee meeting attended. Funding for the stipends is a budgeted item in the Fiscal Year 2025-26 Operating Budget. Staff will also include the estimated cost in future operating budgets.

Rationale for Recommendation

As stated in policies AA.1219a, and AA. 1219b, the MAC and PAC each established a Nominations Ad Hoc Subcommittee to review potential candidates for vacancies on the committees. The MAC and PAC each approved their respective Nominations Ad Hoc Subcommittee's recommended slate of candidates at the joint MAC and PAC meeting held June 12, 2025. The MAC and PAC forward their recommended slate of candidates to the Board for their consideration and appointment.

Concurrence

Member Advisory Committee Nominations Ad Hoc Subcommittee
Member Advisory Committee
Provider Advisory Committee Nominations Ad Hoc Subcommittee
Provider Advisory Committee
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

None

/s/ Michael Hunn *07/31/2025*
Authorized Signature **Date**

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 7, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

6. Authorize and Direct Execution of Amendments to the Companion Contract and the Primary Contract with the California Department of Health Care Services for the CalOptima Health Program of All-Inclusive Care for the Elderly

Contacts

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

Recommended Actions

Authorize and direct the Chair of the Board of Directors to execute Amendment 01 to the Companion Contract and Amendment 02 to the Primary Contract for the Program of All-Inclusive Care for the Elderly between the California Department of Health Care Services and CalOptima Health.

Background

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

In November 2020, DHCS and CalOptima Health entered into a new Primary Contract for PACE, with an effective date of January 1, 2021, that replaced the then existing contract. The Primary Contract specifies, among other terms and conditions, the capitation payment rates CalOptima Health receives from DHCS to provide PACE participants with health care services. The current Primary Contract expires on December 31, 2025.

On September 7, 2023, the Board authorized CalOptima Health to enter into a new agreement, referred to as the Companion Contract, with an effective date of January 1, 2023. The need for the separate Companion Contract stemmed from the eligibility criteria changes in the Medi-Cal program for the Older Adult Expansion (*i.e.,* 50 years old and above regardless of immigration status). The Companion Contract provides for PACE coverage of those members who are considered Unsatisfactory Immigration Status but State Funded (UIS State-Only). Under the Companion Contract, DHCS provides PACE coverage for UIS State-Only members without the federal funds match in capitation. The current Companion Contract expires on December 31, 2025.

Discussion

On June 3, 2025, DHCS provided CalOptima Health with Amendment 01 to the Companion Contract for signatures. This is the first amendment for this contract.

Back to Agenda

Amendment 01 revises the Companion Contract for PACE as follows:

- Increases the State budget funds (maximum amount payable).
- Extends the term of the current contract through December 31, 2026, with the DHCS capitation rates for the UIS population renewed on a CY basis.
- Updates Exhibit B Capitation to include rate adjustments for CY 2023, CY 2024, and CY 2025.

All other terms and conditions shall remain the same.

On June 18, 2025, DHCS provided CalOptima Health with a draft Amendment 02 to the Primary Contract. This is the second amendment for this contract.

Amendment 02 revises the Primary Contract for PACE as follows:

- Increases the State budget funds (maximum amount payable).
- Extends the term of the current contract through December 31, 2026.
- Updates Exhibit A Scope of Work to include provision for Executive Order N-6-22 on Russia Sanctions.
- Updates Exhibit B Capitation to include rate adjustments for CY 2022, and implements CY 2023, CY 2024, and CY 2025 capitation rates.

All other terms and conditions shall remain the same.

If needed, CalOptima Health staff will return to the Board for any further updates to the Companion or Primary Contract that are materially different from the current versions.

Fiscal Impact

The recommended action has no additional fiscal impact beyond what was reported on CalOptima Health's audited financial statements. The amended CY 2023 and CY 2024 PACE rates have been incorporated in CalOptima Health's prior Fiscal Year (FY) 2022-23 and FY 2023-24 financials.

The FY 2024-25 financials will reflect actual performance utilizing the rates included in the amendments to the Companion and Primary Contracts. Staff included the updated rates for the period of July 1, 2025, through December 31, 2025, in the CalOptima Health FY 2025-26 Operating Budget.

Rationale for Recommendation

CalOptima Health's execution of the amendments to the Companion Contract and the Primary Contract are necessary for the continued operation of CalOptima Health PACE.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Back to Agenda

Attachments

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

/s/ Michael Hunn *07/31/2025*
Authorized Signature **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM 6

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

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

Back to Agenda Back to Item

Amendments to Primary Agreement with DHCS	Board Approval
A06 provided an extension of the contract termination date to December 31, 2019.	November 1, 2018
A07 provided revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2018 for the period of January 1, 2018 through December 31, 2018 and applies the Managed Care Organization (MCO) Tax for this period. First time rates for PACE developed using the Rate Development Template (RDT)/experience-based rate methodology. Incorporates additional language updates for various contract provisions, including restrictions on delegation as well as emergency preparedness.	April 4, 2019
A08 provided revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2019 for the period of January 1, 2019 through December 31, 2019 and applies the Managed Care Organization (MCO) Tax for this period. Incorporates additional language updates for other contract provisions, including Nursing Facility Services payment rates.	September 5, 2019
A09 provided an extension of the contract termination date to June 30, 2020.	December 5, 2019
A10 provided an extension of the contract termination date to December 31, 2020 and also provides revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2020 for the period of January 1, 2020 through December 31, 2020.	June 4, 2020
New Primary Agreement: Replaces the previous contract and subsequent amendments in their entirety, effective January 1, 2021. Also extends the contract termination date to December 31, 2024, with DHCS capitation rates renewed on a calendar year basis. The new agreement aligns the PACE DHCS agreement with: • provisions contained in the Managed Care Plan (MCP) Medi-Cal contracts; and • provisions in the CMS 2019 Final Rule.	November 5, 2020
A01 provided an extension of the contract termination date to December 31, 2025 and also provides revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2022 for the period of January 1, 2022 through December 31, 2022 Incorporates Aid Code 38 as an eligible Aid Code for PACE and modifies numbering for provisions throughout the Exhibits, to correct contract cross-references or correct regulatory citations.	November 3, 2022
A02 provides 1) increase to the maximum allowed encumbrance amount, 2) extension of the contract termination date to December 31, 2026 and 3) adjustments to CY 2022 rates and also implements capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2023, CY 2024, and CY 2025 for the period of January 1, 2023 through December 31, 2026 and 4) include provision for Executive Order N-6-22 on Russia Sanctions.	**Pending**

Amendments to Primary Agreement with CMS	Board Approval
A01 CalOptima PACE initiated a waiver to allow Nurse Practitioners to provide primary care at PACE, which was approved by CMS on March 30, 2017 and added *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	December 1, 2016
A02 CalOptima PACE initiated a waiver to allow Community Based Physicians to Serve as the Primary Care Provider for Participants Enrolled in CalOptima PACE, which was approved by CMS on March 12, 2018 and amended *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	September 7, 2017

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

Amendments to "Companion Contract" Agreement with DHCS	Board Approval
Initial effective 1/1/23 provides coverage for Unsatisfactory Immigration Status (UIS) population.	September 7, 2023
A01 provides 1) increase to the maximum allowed encumbrance amount, 2) extension of the contract termination date to December 31, 2026, and 3) revised capitation rates for CY 2023, CY 2024, and CY 2025 for the period of January 1, 2023 through December 31, 2026.	**Pending**

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 7, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contact

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

Recommended Action

Ratify Calendar Year 2024-C Contract Amendment to the Primary Agreement between the California Department of Health Care Services and CalOptima Health.

Background

As a county organized health system, CalOptima Health contracts with the Department of Health Care Services (DHCS) to provide health care services to Medi-Cal members in Orange County. CalOptima Health has a Primary and Secondary Agreement with DHCS. The Primary Agreement contains, among other terms and conditions, the payment rates CalOptima Health receives from DHCS to provide health care services. The Secondary Agreement is a companion agreement to CalOptima Health's Primary Agreement and covers specific Medi-Cal state-supported services for CalOptima Health's members enrolled under the Primary Agreement.

In January 2024, CalOptima Health entered into new Primary and Secondary Agreements with DHCS. The new Primary Agreement is Agreement 23-30235, and the new Secondary Agreement is Agreement 23-30267. The amendments to the new agreements are summarized in Attachment 1. Annual amendments for the DHCS Primary and Secondary agreements are a routine occurrence. The main changes in the current amendment are the finalization of CY 2024 language and benefit changes.

Discussion

Calendar Year (CY) 2024 – C Contract Amendment to the Primary Agreement

Overview

The CalOptima Health Board of Directors Chair signed the finalized CY 2024 - C Contract Amendment in June 2025 to meet the DHCS deadline of June 26, 2025. Staff requests the CalOptima Health Board of Directors ratify the Chair's execution of the amendment with DHCS.

Detailed Discussion

This amendment will bring managed care plan (MCP) agreements, including CalOptima Health's agreement with DHCS, into alignment with requirements effective July 1, 2024. *See* Attachment 3 for further information regarding the changes contained within this amendment.

The CY 2024-C Contract Amendment contains notable language changes, which DHCS has generally already implemented by issuing sub-regulatory guidance such as All Plan Letters. The requirements in DHCS' agreements with MCPs, including CalOptima Health, require CMS approval. DHCS'

Back to Agenda

implementation of these requirements via sub-regulatory guidance prior to their formal inclusion in the MCP agreements is largely due to the lengthy CMS review process. While the contractual requirements are being formalized, CalOptima Health staff has implemented the required operational changes and other contractual requirements by following the sub-regulatory guidance.

The amendment does not contain any rate changes or otherwise set any new rates. Staff received updated final CY 2024 rates from the DHCS via a separate amendment and received authority to execute that amendment during the April 3, 2025, meeting of the Board of Directors.

Fiscal Impact

The provisions in the contract amendment are operational in nature. There is no additional fiscal impact beyond what has already been reflected in the Fiscal Year (FY) 2023-24 and FY 2024-25 financials.

Rationale for Recommendation

CalOptima Health's execution of the CY 2024-C Contract Amendment to its Primary Agreement with DHCS is necessary for the continued operation of CalOptima Health's Medi-Cal program.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Attachment 1_Appendix Summary of Amendments to Primary and Secondary Agreements with DHCS
2. Attachment 2_CY 2024-C CalOptima Health Contract Amendment (Primary Agreement + Amendments)
3. Attachment 3_Additional CY 2024-C Contract Amendment Detail

/s/ Michael Hunn *07/31/2025*
Authorized Signature **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM 7

The following is a summary of amendments to the Primary Agreement (23-30235) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Primary Agreement	Board Approval
Primary Agreement 23-30235 provides language and benefit changes effective January 1, 2024.	December 7, 2023
A-01 incorporates Calendar Year (CY) 2024 capitation rates.	March 7, 2024
A-02 incorporates language and benefit changes effective January 1, 2024.	August 1, 2024
A-03 extends the term of the Primary Agreement and Secondary Agreement (23 – 30267) (by default) to December 31, 2025.	November 7, 2024
A-04 incorporates updated final Calendar Year (CY) 2024 capitation rates.	April 3, 2025
A-05 incorporates final Calendar Year (CY) 2025 capitation rates and extends the Enhanced Care Management (ECM) risk corridor rating period through December 31, 2025.	April 3, 2025
A-06 incorporates language and benefit changes effective January 1, 2024.	June 5, 2025
A-07 incorporates language and benefit changes effective July 1, 2024.	August 7, 2025

The following is a summary of amendments to the Primary Agreement (08-85214) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010

Back to Agenda Back to Item

Amendments to Primary Agreement	Board Approval
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012
A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014

Amendments to Primary Agreement	Board Approval
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015
A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017

Amendments to Primary Agreement	Board Approval
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A–45 incorporates the new requirements of the 2018 Final Rule Amendment, Behavioral Health Treatment (BHT) and State Fiscal Year (SFY) 2018 – 19 capitation rates	June 7, 2018 August 1, 2019 August 6, 2020
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020
A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021
A-52 incorporates Calendar Year (CY) 2021 base amendment contract language.	October 7, 2021
A-53 incorporates Calendar Year (CY) 2021 fall amendment contract language.	October 7, 2021
A-54 extends the Primary Agreement with DHCS to December 31, 2022.	October 7, 2021
A-55 incorporates full dual rates for Calendar Year (CY) 2022.	March 3, 2022
A-56 incorporates updated Bridge Period (July 1, 2019 – December 31, 2020) capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) and Unsatisfactory Immigration Status (UIS) members, and includes new corresponding rate tables that split each existing category into a SIS and UIS version.	October 1, 2020
A-57 incorporates Calendar Year (CY) 2022 risk mitigation language.	March 3, 2022
A-58 incorporates the COVID Vaccination Incentive Program.	March 3, 2022

Amendments to Primary Agreement	Board Approval
A-59 incorporates new Calendar Year (CY) 2022 capitation rates and benefit changes implemented in CY 2022	August 5, 2021 March 3, 2022 August 4, 2022
A-60 incorporates new benefits changes for Calendar Year (CY) 2022.	August 4, 2022
A-61 incorporates new benefit changes for Calendar Year (CY) 2022.	May 4, 2023
A-62 extends the Primary Agreement with DHCS to December 31, 2023.	May 5, 2022
A-63 incorporates new benefits changes for Calendar Year (CY) 2023.	February 2, 2023
A-64 incorporates updated Calendar Year (CY) 2021 capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members.	Not applicable due to non – substantive changes.
A-65 incorporates updated Calendar Year (CY) 2022 Public Health Emergency (PHE) capitation rates.	November 2, 2023
A-66 incorporates updated Calendar Year 2022 Capitation Payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members and includes new corresponding rate tables that split each existing category into a SIS version and UIS version.	Not applicable due to non – substantive changes.
A-67 incorporates Calendar Year (CY) 2023 capitation rates and new benefits for CY 2023.	December 7, 2023
A-68 incorporates revised Calendar Year (CY) 2022 CCI Full Dual capitation rates.	June 1, 2023
A-69 incorporates updated Calendar Year (CY) 2023 capitation rates.	October 3, 2024

The following is a summary of amendments to the Secondary Agreement (23-30267) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Secondary Agreement	Board Approval
Agreement 23 – 30267 covers specific state – supported services to CalOptima Health's members enrolled under CalOptima Health's Primary Agreement (23 – 30235).	December 7, 2023
A-01 incorporates Calendar Year (CY) 2024 capitation rates.	March 7, 2024
A-02 incorporates updated final Calendar Year (CY) 2024 capitation rates.	April 3, 2025
A-03 incorporates final Calendar Year (CY) 2025 capitation rates.	April 3, 2025

The following is a summary of amendments to the Secondary Agreement (08-85221) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011

A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-09 incorporates updated Calendar Year (CY) 2022 Public Health Emergency (PHE) capitation rates.	November 2, 2023
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021

The following is a summary of amendments to the Secondary Agreement (22-20494) approved by the CalOptima Health Board of Directors (Board) to date:

Agreement 22-20494 incorporates both Hyde services ("Private Services") and the new Unsatisfactory Immigration Status members from January 1, 2023 to December 31, 2023.	December 1, 2022
A-01 incorporates rates for CY 2023 for Hyde services (now referred to as "Private Services") and the new Unsatisfactory Immigration Status (UIS) members.	December 1, 2022
A-02 incorporates updated Calendar Year (CY) 2023 capitation rates.	October 3, 2024

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2022.	June 3, 2021
A-06 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	May 5, 2022
A-07 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	October 6, 2022
A-08 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	Not applicable due to non – substantive changes.
A-09 extends Agreement 16 – 93274 with DHCS to December 31, 2024.	May 4, 2023
A-10 extends Agreement 16 – 93274 with DHCS to December 31, 2025.	May 2, 2024

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

The following is a summary of amendments to CalOptima Health's Agreement for Disclosure and Use of DHCS Data (2023 Post – Expiration Data Use Agreement (DUA)) and 2024 Operational Readiness (OR) DUA.

Amendments to Data Use Agreement	Board Approval
CY 2023 Data Use Agreement (DUA) allows for the exchange of information between DHCS and CalOptima Health after the current contract expires on December 31, 2023.	November 2, 2023
CY 2024 Operational Readiness (OR) DUA allows DHCS to initiate and execute the necessary data releases ahead of January 1, 2024 for DHCS to share necessary data with CalOptima Health.	November 2, 2023

Exhibit A
SCOPE OF WORK

I. Service Overview

Contractor agrees to provide to the California Department of Health **Care** Services (DHCS) the following services described herein:

Provide health care services to eligible Medi-Cal recipients within the scope of Medi-Cal benefits as defined in the contents of the Contract.

II. Service Location

The services must be performed at all contracting and participating facilities of Contractor.

III. Service Hours

The Services must be provided as needed on a 24-hour, seven days a week basis.

IV. Contract Representatives

A. The Contract representatives during the term of this Contract will be:

Department of Health Care Services	**Contractor**
Managed Care Operations Division Attention: Chief, Procurement & Contract Development Branch Telephone: (916) 449-5000	Orange County Health Authority, A Public Agency dba CalOptima Health Attention: Michael Hunn, CEO Telephone: (657) 900-1481 Fax: N/A Email: Michael.hunn@caloptima.org

B. Direct all inquiries to:

Back to Agenda Back to Item

Exhibit A
SCOPE OF WORK

Department of Health Care Services	**Contractor**
Managed Care Operations Division Attention: Contracting Officer 1501 Capitol Avenue, Suite 71.4001 P.O. Box Number 997413, Mail Stop 4408 Sacramento, CA 95899-7413 Telephone: (916) 449-5000	Orange County Health Authority, A Public Agency dba CalOptima Health Attention: Michael Wood, Manager Regulatory Affairs & Compliance 505 City Parkway West Orange, CA 92868 Telephone: (714) 246-8415 Fax: (714) 246-6418 Email: mwood@caloptima.org

C. Either party may make changes to the information in provision 4 of this Exhibit A by giving written notice to the other party. Said changes must not require an amendment to this Contract.

V. Americans with Disabilities Act

Contractor agrees to ensure that deliverables developed and produced, pursuant to this Agreement must comply with the accessibility requirements of Section 508 of the Rehabilitation Act of 1973 (29 United States Code (USC) section 794d) and the Americans with Disabilities Act of 1990 (ADA) (42 USC sections 12101, *et seq.*), as amended, and regulations implementing those statutes as set forth in 36 Code of Federal Regulations (CFR) part 1194 and 28 CFR part 36, as applicable. In 1998, Congress amended the Rehabilitation Act of 1973 to require Federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California Government Code section 7405 codifies section 508 of the Rehabilitation Act (29 USC section 794d) and the regulations implementing the Rehabilitation Act at 36 CFR part 1194, requiring accessibility of EIT.

The provision of the services is subject to the provisions set forth in the Exhibits and Attachments appended hereto.

Back to Agenda Back to Item

Exhibit A, ATTACHMENT I

1.0 Definitions

As used in this Contract, unless otherwise expressly provided the following definitions of terms governs the construction of this Contract:

Abuse means practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program.

Admission, Discharge, and Transfer (ADT) Feed means a standardized data feed, updated consistently in real-time sourced from a health facility, such as a hospital, that includes Members' demographic and healthcare Encounter Data at time of admission, discharge, and/or transfer from the facility. Demographic information within the feed must meet requirements of the most recent version of the California Data Exchange Framework's Technical Requirements for Exchange Policy and Procedure and conform to United States Core Data for Interoperability (USCDI) requirements of the California Data Exchange Framework.

Administrative Cost means only those cost that arise out of Contractor's operations as specified in 28 California Code of Regulations (CCR) section 1300.78.

Administrative Subcontractor means a Subcontractor that contractually assumes administrative obligations of Contractor under the Contract. Administrative obligations include functions such as Credentialing verification or claims processing. However, functions related to coordinating or directly delivering health care services to Members, such as Care Coordination are not administrative functions.

Adult Day Health Care (ADHC) means an organized day program of therapeutic, social and health activities, and services provided to persons 55 years or older or other adults with functional impairments, either physical or mental, for the purpose of restoring or maintaining optimal capacity for self-care as set forth in 22 CCR section 78007.

Advance Directive means a written instruction, such as a living will or durable power of attorney for health care, recognized under California law, whether statutory or as recognized by the California courts, relating to the provision of health care when a Member is incapacitated.

Adverse Benefit Determination (ABD) means any of the following actions taken by Contractor:

A. The denial or limited authorization of a requested service, including determinations based on the type or level of a Covered Service, Medical Necessity;

B. The reduction, suspension, or termination of a previously authorized Covered Service;

C. The denial, in whole or in part, of payment for a Covered Service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of Clean Claim is not an ABD;

D. The failure to provide Covered Services in a timely manner;

E. The failure to act within the required timeframes for standard resolution of Grievances and Appeals;

F. The denial of the Member's request to obtain services out-of-Network when a Member is in an area with only one Medi-Cal managed care health plan; or

G. The denial of a Member's request to dispute financial liability.

Affiliate means an entity or an individual that directly or indirectly through one or more intermediaries' controls, or is controlled by, or is under control of Contractor and that provides services to or receives services from Contractor.

All Plan Letter (APL) or **Policy Letter (PL)** means a binding document that has been dated, numbered, and issued by Department of Health Care Services (DHCS) that provides clarification of Contractor's contractual obligations, implementation instructions for Contractor's contractual obligations due to changes in State and federal law or judicial decisions, and/or guidance with regulatory force and effect when DHCS interprets, implements, or makes specific relevant State statutes under its authority.

Allied Health Personnel means specially trained, licensed, or credentialed health workers other than physicians, podiatrists and nurses.

Alternative Format Selection (AFS) means the choice a Member or a Member's Authorized Representative (AR) makes to receive information and materials in an alternate format, such as braille, large font, and electronic media, including audio or data compact discs.

American Indian means a Member who meets the criteria for an "Indian" under 42 Code of Federal Regulations (CFR) section 438.14(a).

Appeal means a review by Contractor of an Adverse Benefit Determination (ABD) which includes one of the following actions:

A. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service;

B. A reduction, suspension, or termination of a previously authorized service;

C. The denial, in whole or in part, of payment for a Covered Service, except payment denials based solely because the claim does not meet the definition of a Clean Claim;

D. Failure to provide services in a timely manner; or

E. Failure to act within the timeframes provided in 42 CFR section 438.408(b).

Application Programming Interface (API) means a way for two or more computer programs to communicate with each other. The calls that make up the API are also known as subroutines, methods, requests, or endpoints.

Asthma Preventive Services (APS) is defined as a service that provides information about the basic facts of asthma, proper use of long-term controllers and quick relief medications, evidence-based self-management techniques and self-monitoring skills, and actions to mitigate or control environmental exposures that exacerbate asthma symptoms. Asthma Preventive Services includes evidence-based asthma self-management education and in-home environmental trigger assessments, consistent with the National Institutes of Health's Guidelines for the Diagnosis and Management of Asthma.

Authorized Representative (AR) means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Hearings, Independent Medical Reviews, and in any other capacity, as specified by the Member or Potential Member.

Auxiliary Aid means "auxiliary aids and services" as defined in 28 CFR section 36.303(b) that assist disabled Members to communicate, receive and understand information.

Basic Population Health Management (Basic PHM) means an approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting. Basic PHM includes federal requirements for Care Coordination.

Behavioral Health means mental health conditions and Substance Use Disorders (SUD).

Behavioral Health Services means Specialty Mental Health Services (SMHS), Non-specialty Mental Health Services (NSMHS), and Substance Use Disorders (SUD) treatment.

Behavioral Health Treatment (BHT) means services and treatment programs for the treatment of Autism Spectrum Disorder (ASD), as specified in the California Medicaid State Plan, including applied behavioral analysis and other evidence-based intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member less than 21 years of age who has been diagnosed with ASD, or for whom a licensed physician, surgeon, or psychologist has determined BHT is Medically Necessary.

BHT Provider means a Qualified Autism Services (QAS) Provider, QAS Professional, or QAS Paraprofessional.

Beneficiary Identification Card means a plastic card issued by DHCS to a Member confirming Medi-Cal eligibility.

Bright Futures Periodicity Schedule means the *Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care* and guidelines published by the American Academy of Pediatrics and Bright Futures, in accordance with which all Members less than 21 years of age must receive well child assessments, screenings, and services.

California Advancing and Innovating Medi-Cal (**CalAIM) Terms and Conditions** means those terms and conditions issued and approved by the federal Centers for Medicare & Medicaid Services (CMS), including any attachments, appendices, or similar documents, and subsequent amendments thereto, that govern implementation of the respective components of the CalAIM initiative pursuant to Article 5.1 of Chapter 7 of Part 3 of Division 9 of Welfare and Institutions Code (W&I). CalAIM Terms and Conditions must include, at a minimum, any terms and conditions specified in the following:

A. CalAIM Demonstration, Number 11-W-00193/9, as approved by CMS pursuant to 42 United States Code (USC) section 1315, including for any applicable extension period, or for any period otherwise specified in the CalAIM Terms and Conditions.

B. Any associated Medicaid waivers as approved by CMS pursuant to 42 USC section 1396n, including but not limited to the CalAIM Section 1915(b) Waiver

Control Number CA 17.R10, that are necessary to implement a CalAIM component, including for any applicable extension period, or for any period otherwise specified in the CalAIM Terms and Conditions.

California Children's Services (CCS)-Eligible Condition means a medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 *et seq*.

California Children Services (CCS) Provider means any of the following Providers when used to treat Members for a CCS-Eligible Condition:

A. A medical Provider that is paneled by the CCS Program, pursuant to Health and Safety Code (H&S), Article 5 (commencing with section 123800) of Chapter 3 of Part 2 of Division 106.

B. A licensed acute care hospital approved by the CCS Program.

C. A special care center approved by the CCS Program.

CCS Case Manager means an individual identified as a single point-of-contact responsible for the provision of case management services and facilitation of Care Coordination for a Member receiving services under the California Children's Services (CCS) Program.

CCS Liaison means primary points of contact for the coordination of services between Contractor and county CCS Program who ensure the appropriate communication and care coordination are ongoing between the Contractor and county CCS Program, facilitate quarterly meetings, and provide updates to the county CCS Program as appropriate.

CCS Program means a State program administered as a partnership between the county health department and the DHCS to provide Medically Necessary services to treat California Children's Services (CCS)-Eligible Conditions.

Capitation Payment means a regularly scheduled payment made by DHCS to Contractor on behalf of each Member for each month the Member is enrolled with Contractor that is based on the actuarially sound capitation rate for the provision of Covered Services and paid regardless of whether a Member receives services during the period covered by the payment.

Care Coordination means Contractor's coordination of care delivery and services for Members, either within or- across delivery systems including:

A. Services the Member receives by Contractor;

B. Services the Member receives from any other managed care health plan;

C. Services the Member receives in Fee-For-Service (FFS);

D. Services the Member receives from out-of-Network Providers;

E. Services that the Member receives through carve-out programs, such as pharmacy, Substance Use Disorder (SUD), mental health, and dental services; and

F. Services the Member receives from community and social support Providers.

Care Management Plan (CMP) means a written plan that is developed with input from the Member and/or their family member(s), parent, legal guardian, Authorized Representative (AR), caregiver, and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals, and preferences, and make recommendations for clinical and non-clinical service needs.

Center of Excellence means a designation assigned to a transplant program by DHCS upon confirmation that the transplant program meets DHCS' criteria.

Certified Nurse Midwife (CNM) means a registered nurse who has successfully completed a program of study and clinical experience meeting the State guidelines or has been certified by an organization recognized by the State.

Child/Children and Youth, regardless of whether the term is capitalized or not, means a Member/Members less than 21 years of age unless otherwise specified.

Children and Youth with Special Health Care Needs (CYSHCN) means Children and Youth who have or are at increased risk for chronic physical, developmental, behavioral, or emotional condition and who also require health or related services of a type or amount beyond that required by Children and Youth generally. The identification, assessment, treatment, and coordination of care for CYSHCN must comply with the requirements of 42 CFR sections 438.208(b)(3), 438.208(b)(4), and 438.208(c)(2) – (4).

Clean Claim means a claim that can be processed without obtaining additional information from the Provider or from a third party, including bills, or invoices that meet DHCS established billing and invoicing requirements.

Cold-Call Marketing means Contractor's or its agent's unsolicited personal contact with a Member or a Potential Member for the purpose of Marketing.

Community Based Adult Services (CBAS) means skilled nursing, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services provided in an outpatient, facility-based program, as set forth in the CalAIM Terms and Conditions, or as set forth in any subsequent demonstration amendment or renewal, or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS services.

CBAS Discharge Plan of Care means a discharge plan of care based on the Member's Community Based Adult Services (CBAS) assessment that is prepared by the CBAS Provider pursuant to 22 CCR section 78345 before the date of the Member's first reassessment and reviewed and updated at the time of each reassessment and prior to discharge.

CBAS Emergency Remote Services (ERS) means the following services, provided in alternative Service Locations such as a community setting or the Member's home, and/or as appropriate, via Telehealth or live virtual video conferencing, as clinically appropriate: professional nursing care, personal care services, social services, Behavioral Health Services, speech therapy, therapeutic activities, registered dietician-nutrition counseling, physical therapy, occupational therapy, and meals.

CBAS Individual Plan of Care (IPC) means a written plan of care developed by a Community Based Adult Services (CBAS) center's multidisciplinary team, as specified in the CalAIM Terms and Conditions, or as specified in any subsequent demonstration amendment or renewal, or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS.

CBAS Provider means an Adult Day Health Care (ADHC) center that is licensed by the California Department of Public Health (CDPH) to provide ADHC services, is enrolled as a Medi-Cal Provider, and has been certified as a Community Based Adult Services (CBAS) Provider by the California Department of Aging.

Community Health Assessment (CHA) means a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. Public health departments such as State, local, territorial, or Tribal develop CHAs to meet voluntary Public Health Accreditation Board (PHAB) standards and State Future of Public Health funding requirements. A variety of tools and processes may be used to conduct these population-level assessments. The essential feature, as defined by the PHAB, is that the assessment is developed through a participatory, collaborative process with various key sectors of the community.

Community Health Improvement Plan (CHIP) means the output of the CHA when produced by public health departments (local, territorial, State, or Tribal) for Public Health Accreditation Board (PHAB) accreditation, State Local Assistance Spending Plan funding allocation, and non-profit hospitals to meet federal and State requirements.

Community Health Worker (CHW) means an individual known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, and as set forth in APL 22-016.

Community Reinvestment Plan means a document outlining the reinvestment activities in local communities.

Community Supports means substitute services or settings to those required under the California Medicaid State Plan that Contractor may select and offer to their Members pursuant to 42 CFR section 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.

Community Supports Provider means entities that Contractor has determined can provide the Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees)*.

Complex Care Management (CCM) means an approach to care management that meets differing needs of high and rising-risk Members, including both longer-term chronic Care Coordination for chronic conditions and interventions for episodic, temporary needs. Contractors must provide CCM in accordance with all National Committee for Quality Assurance (NCQA) CCM requirements.

CCM Care Manager means an individual identified as a single point-of-contact responsible for the provision of Complex Care Management (CCM) services for a Member.

Confidential Information means facts, documents, or records in any form that are recognized as "confidential" by any law, regulation, or contract.

Contract means this written agreement between DHCS and Contractor.

Contract Revenues means the amount of Medi-Cal managed health care Capitation Payments, Supplemental Payments, additional payments, and other revenue paid to Contractor by DHCS under this Contract.

Contractor's Representative means an individual appointed by Contractor who is responsible for implementing this Contract, receiving notices on this Contract, and taking actions and making representations related to the compliance with this Contract.

Correctional Facility means State prisons, county jails, and youth correctional facilities.

Corrective Actions means specific identifiable activities or undertakings of Contractor which address Contract deficiencies or noncompliance.

Cost Avoid or **Cost Avoidance** means the practice of requiring Providers to bill liable third parties prior to seeking payment from the Medi-Cal program.

County Social Services Department means a county agency responsible for determining the initial and continued eligibility of an individual for participation in the Medi-Cal program or for providing services as specified in this Contract.

Covered Services means those health care services, set forth in W&I sections 14000 *et seq.* and 14131 *et seq.,* 22 CCR section 51301 *et seq*., 17 CCR section 6800 *et seq*., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, this Contract, and APLs that are made the responsibility of Contractor pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

Covered Services do not include:

A. Home and Community-Based Services (HCBS) program as specified in Exhibit A, Attachment III, Subsections 4.3.15 (*Services for Persons with Developmental Disabilities*), 4.3.20 (*Home and Community-Based Services Programs*) regarding waiver programs, 4.3.21 (*In-Home Supportive Services*), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under this Contract, as specified in Exhibit A, Attachment III, Subsection 4.3.11.F.4 (*Targeted Case Management Services*), regarding services for Members less than 21 years of age. Contractor is financially responsible for the payment of all EPSDT services;

B. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (*California Children's Services*), except for Contractors providing Whole Child Model (WCM) services;

C. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (*Mental Health Services*);

D. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (*Alcohol and Substance Use Disorder Treatment Services*);

E. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (*Services for All Members*);

F. Direct Observed Therapy for Treatment of Tuberculosis as specified in Exhibit A, Attachment III, Subsection 4.3.18 (*Direct Observed Therapy for Treatment of Tuberculosis*);

G. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, Contractor is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (*Dental*) regarding dental services;

H. Prayer or spiritual healing as specified in 22 CCR section 51312;

I. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, Contractor is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (*School-Based Services*);

J. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH);

K. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services;

L. State Supported Services;

M. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (*Targeted Case Management Services*). However, if Members less than 21 years of age are not eligible for or accepted by a Regional Center (RC) or a local

government health program for TCM services, Contractor must ensure access to comparable services under the EPSDT benefit in accordance with APL 23-005;

N. Childhood lead poisoning case management provided by county or State health departments;

O. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living;

P. End of life services as stated in Health and Safety Code (H&S) section 443 *et seq*., and APL 16-006; and

Q. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with APL 22-012.

Credentialing means the process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure, and professional association membership.

Deemed Exhaustion means Contractor's failure to adhere to the notice and timing requirements in responding to a Member's Appeal of an Adverse Benefit Determination (ABD), which allows a Member to immediately request a State Hearing.

Department of Health Care Services (DHCS) or **Department** means the single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health-related programs, as provided by statute and/or regulation.

DHCS Comprehensive Quality Strategy means the federally required written strategy produced by the State, pursuant to 42 CFR section 438.340 that assesses and improves the quality of health care and services furnished by Medi-Cal managed care health plans.

DHCS Contract Manager or **DHCS Program Contract Manager** means the designated DHCS employee who is the primary contact within DHCS for this Contract, and responsible for receiving and sending notices and other documents from/to Contractor relating to this Contract.

DHCS Contracting Officer means the DHCS individual authorized to act on behalf of DHCS to make decisions and direct appropriate actions under this Contract.

Department of Managed Health Care (DMHC) means the California department responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.

Developmental Disability (DD) means, as defined by the Lanterman Developmental Disabilities Services Act (1977) at W&I section 4512(a)(1), a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. This term includes intellectual disability, cerebral palsy, epilepsy, and autism. This term also includes disabling conditions found to be closely related to intellectual disability, but does not include other handicapping conditions that are solely physical in nature.

Director means the Director of DHCS.

Directed Payment Initiative means a payment arrangement that directs certain expenditures made by Contractor under this Contract and that is either approved by CMS as described in 42 CFR section 438.6(c) or established pursuant to 42 CFR sections 438.6(c)(1)(iii)(A) and 438.6(c)(2)(ii) and documented in a rate certification approved by CMS.

Discharge Planning means planning that begins at the time of admission to a hospital or facility to ensure that necessary care, services, and supports are in place in the community before a Member leaves the hospital or facility in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

Discrimination Grievance means any complaint or grievance alleging discrimination prohibited by State non-discrimination law, including, without limitation, the Unruh Civil Rights Act and GC section 11135, and federal non-discrimination law, including, without limitation, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973 (29 USC sections 794 and 794d), as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; and Section 1557 of the Patient Protection and Affordable Care Act of 2010 (42 USC section 18116).

Doula means a birth worker who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, otherwise known as the perinatal period, for up to one year after pregnancy and provides support during miscarriage, stillbirth, and abortion (pregnancy termination) as set forth in APL 23-024.

Downstream Subcontractor means an individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A

Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.

Downstream Fully Delegated Subcontractor means a Downstream Subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, through the Subcontractor, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Downstream Fully Delegated Subcontractor.

Downstream Partially Delegated Subcontractor means a Downstream Subcontractor that contractually assumes some, but not all, duties and obligations of a Subcontractor under the Contract, including, for example, obligations regarding specific Member populations or obligations regarding a specific set of services. Individual physician associations and medical groups often operate as Downstream Partially Delegated Subcontractors.

Downstream Administrative Subcontractor means a Downstream Subcontractor that contractually assumes administrative obligations of a Subcontractor under the Contract. Administrative obligations include functions such as credentialing verification or claims processing. However, functions related to coordinating or directly delivering health care services for Members, such as Utilization Management (UM) or Care Coordination, are not administrative functions.

Downstream Subcontractor Agreement means a written agreement between a Subcontractor and a Downstream Subcontractor or between any Downstream Subcontractors. The Downstream Subcontractor Agreement must include a delegation of Contractor's and Subcontractor's duties and obligations under the Contract.

Drug Medi-Cal (DMC) means the State system wherein Members receive Covered Services from DMC-certified Substance Use Disorder (SUD) treatment Providers.

Drug Medi-Cal Organized Delivery System (DMC-ODS) means a program for the organized delivery of Substance Use Disorder (SUD) services to Medi-Cal-eligible individuals with SUD residing in a county that has elected to participate in the DMC-ODS. Critical elements of DMC-ODS include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria® for SUD treatment services, increased local control and accountability, greater administrative oversight, creation of utilization controls to improve care and efficient use of resources, evidence-based practices in substance use treatment, and increased coordination with other systems of care.

Durable Medical Equipment (DME) means Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home.

Dyadic Care means to serve both parent(s) or caregiver(s) and Child together as a dyad and is a form of treatment that targets family well-being as a mechanism to support healthy Child development and mental health. It is provided within pediatric Primary Care settings whenever possible and can help identify Behavioral Health interventions and other Behavioral Health issues, provide referrals to services, and help guide the parent-Child or caregiver-Child relationship. Dyadic Care fosters team-based approaches to meeting family needs, including addressing mental health and social support concerns, and it broadens and improves the delivery of pediatric Preventive Care.

Dyadic Service means a family and caregiver-focused Model of Care intended to address developmental and Behavioral Health conditions of Children as soon as they are identified. Dyadic Services include Dyadic Behavioral Health (DBH) well-Child visits, Dyadic Comprehensive Community Supports Services, Dyadic Psychoeducational Services, and Dyadic Family Training and Counseling for Child Development.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) means the provision of Medically Necessary comprehensive and preventive health care services provided to Members less than 21 years of age in accordance with requirements in 42 USC sections 1396a(a)(43) and 1396d(a)(4)(B) and (r), 42 CFR section 441.50 *et seq*., and as required by W&I sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or Behavioral Health conditions.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one or more of the following:

A. Placing the Member’s health in serious jeopardy;

B. Serious impairment to bodily functions;

C. Serious dysfunction to any bodily organ or part; or

D. Death.

Emergency Medical Transportation (EMT) means transportation services for an Emergency Medical Condition and includes emergency air transportation.

Emergency Preparedness and Response Plan means the plan identified and described in Exhibit A, Attachment III, Section 6.1 (*General Requirements*).

Emergency Services means inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1).

Encounter means an instance of direct Provider-to-Member interaction, regardless of the setting, where the Provider is diagnosing, evaluating, or treating the Member's condition.

Encounter Data means the information that describes health care interactions between Members and Providers relating to the receipt of any item(s) or service(s) by a Member under this Contract and subject to the standards of 42 CFR sections 438.242 and 438.818.

Enhanced Care Management (ECM) means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members who meet ECM Populations of Focus eligibility criteria through a systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

ECM Lead Care Manager means a Member's designated Enhanced Care Management (ECM) care manager who works for the ECM Provider organization or as staff of Contractor, and is responsible for coordinating all aspects of ECM and any Community Supports as a part of the Member's multi-disciplinary care team, which may include other care managers.

ECM Populations of Focus/Populations of Focus means the populations identified in Exhibit A, Attachment III, Subsection 4.4.2 (*Populations of Focus for Enhanced Care Management*).

ECM Provider means community-based entities with experience and expertise providing intensive, in-person care management services to Members in one or more of the Populations of Focus for Enhanced Care Management (ECM).

Enrollment means the process by which a Potential Member becomes a Member of Contractor.

Excluded Entities or **Excluded Providers** means entities, Providers, and individuals that are excluded from participation in federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid Fraud.

Excluded Service means a service that is covered by the Medi-Cal program but is not a Covered Service, and is carved out of this Contract for the provision of Covered Services.

External Quality Review (EQR) means the analysis and review by the External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that Contractor, its Subcontractor, its Downstream Subcontractor, or its Network Provider furnishes to Members.

External Quality Review Organization (EQRO) means an organization that meets the competence and independence requirements set forth in 42 CFR section 438.354, and performs EQR and other EQR-related activities as set forth in 42 CFR section 438.358 pursuant to its contract with DHCS.

Family Therapy means a type of psychotherapy covered under the Medi-Cal Non-specialty Mental Health Services (NSMHS) benefit and is composed of at least two family members. Family therapy sessions address family dynamics as they relate to mental status and behavior(s) and is focused on improving relationships and behaviors in the family and between family members, such as between a Child and parent(s) or caregiver(s).

Federal Financial Participation (FFP) means federal expenditures provided to reimburse allowable State expenditures made under the approved California Medicaid State Plan, waivers, or other similar federal Medicaid authority.

Federally Qualified Health Center (FQHC) means an entity defined in 42 USC section 1396d(l)(2)(B).

Federally Qualified Health Maintenance Organization (FQHMO) means a prepaid health delivery plan that has fulfilled the requirements of the Health Maintenance Organization Act, along with its amendments and regulations, and has obtained the federal government's qualification status under 42 USC section 300e.

Fee-For-Service (FFS) means the Medi-Cal delivery system in which Providers submit claims to and receive payments from DHCS for Medi-Cal Covered Services rendered to Medi-Cal recipients.

File and Use means a submission to DHCS that does not need review and approval prior to use or implementation, but for which DHCS can require edits on or after implementation.

Financial Performance Guarantee means cash or cash equivalents which are immediately redeemable upon demand by DHCS, in an amount determined by DHCS, which must not be less than one full month’s Contract Revenues.

Financial Statements means reports prepared by Contractor to present its financial performance and position at a point in time, and include a balance sheet, income

statement, statement of cash flows, statement of equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles (GAAP).

Fiscal Year (FY) means any 12-month period for which annual accounts are kept. The State Fiscal Year (SFY) is July 1 through June 30; the federal Fiscal Year (FY) is October 1 through September 30.

Fraud means an intentional deception or misrepresentation made by persons with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person and includes any act that constitutes Fraud under applicable federal or State law, including 42 CFR section 455.2 and W&I section 14043.1(i).

Freestanding Birthing Center (FBC) means a health facility that is not a hospital, where childbirth is planned to occur away from the pregnant woman's residence, and that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are in their scope of work as defined in 42 USC section 1396d(I)(3)(B).

Fully Delegated Subcontractor means a Subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Fully Delegated Subcontractor.

Governing Board means Contractor's board of directors or a similar body, and/or its executive management, that has the authority to manage and direct Contractor's affairs and activities, including, but not limited to, approving initiatives and establishing Contractor's policies and procedures.

Grievance means any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to: the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Contractor processes. If contractor is unable to distinguish between a grievance and an inquiry, it must be considered a grievance.

Health Disparity means differences in health, including mental health, and outcomes closely linked with social, economic, and environmental disadvantage, which are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics such as race, ethnicity, age, disability, sexual orientation, gender identity, socio-economic status, geographic location, and other factors historically linked

to exclusion or discrimination are known to influence the health of individuals, families, and communities.

Health Equity means the reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.

Health Inequity means a systematic difference in the health status of different population groups arising from the social conditions in which Members are born, grow, live, work, and/or age, resulting in significant social and economic costs both to individuals and societies.

Healthcare Effectiveness Data and Information Set (HEDIS®) means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

Implementation Period means the period of time in which Contractor is undertaking any readiness requirements required by DHCS before performance of the Contract begins. The Implementation Period begins with DHCS awarding this Contract and extends to the effective date that begins the Operations Period.

Incentive Arrangement means any payment mechanism approved by Centers for Medicare & Medicaid Services (CMS) in accordance with the requirements of 42 CFR section 438.6(b) under which Contractor may receive incentive payments in addition to Capitation Payments for meeting targets specified in accordance with this Contract, including but not limited to Exhibit B, Subsection 1.1.14.D (*Special Contract Provisions Related to Payment*).

Independent Medical Review (IMR) means a review of Contractor's denial of a Member's request for health care service as not Medically Necessary, experimental, or investigational by an independent physician(s) who is contracted with DMHC. The IMR decision is binding on Contractor but not the Member who may still request a State Hearing after an IMR pursuant to H&S section 1374.30 and 28 CCR section 1300.74.30.

Indian Health Care Provider (IHCP) means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (IHCIA) at 25 USC section 1603.

Indian Health Service (IHS) means an agency within the United States Department of Health and Human Services responsible for providing federal health services to American Indians and Alaska Natives. The IHS is the principal federal health care provider and health advocate for these populations and provides them with a comprehensive Indian health care delivery system.

Indian Health Services Memorandum of Agreement Provider (IHS/MOA) means an Indian Health Service (IHS) program funded under the authority of Public Law 93-638 at 25 USC section 5301 et seq. These programs have elected to participate in Medi-Cal as IHS/MOA providers. IHS/MOAs are subject to the payment terms of APL 17-020. The list of eligible IHS/MOA providers is found in APL 17-020, Attachment #1. These providers receive a federally established All-Inclusive Rate that is updated annually by the federal Office of Management and Budgets and published in APL 17-020, Attachment #2.

In-Home Supportive Services (IHSS) means services provided to Members by a county in accordance with the requirements set forth in W&I sections 12300 *et seq.*, 14132.95, 14132.952, and 14132.956.

Initial Health Appointment (IHA), previously called Initial Health Assessment, means an assessment that must be completed within 120 days of Contractor enrollment for new Members and must include a history of the Member's physical and Behavioral Health, an identification of risks, an assessment of need for preventive screens or services and health education, and a diagnosis and plan for treatment of any diseases.

Incurred but Not Reported (IBNR) Claim Estimate means a financial accounting of all services that have been performed, but have not been invoiced or recorded, or estimates of costs for medical services provided for which a claim has not yet been filed.

Intermediate Care Facility (ICF) means a residential facility certified and licensed by the State to provide medical services at a lower level of care than is provided at Skilled Nursing Facilities (SNFs), and meets the standards specified in 22 CCR section 51212. An Intermediate Care Facility for the Developmentally Disabled (ICF/DD) includes the following types:

A. ICF/DD-Habilitative as defined in Health and Safety Code (H&S) section 1250(e);

B. ICF/DD-Nursing as defined in H&S section 1250(h); and

C. ICF/DD as defined in H&S section 1250(g) and does not include the ICF/DD-Continuous Nursing Care Program.

Joint Commission (JC) means the organization that provides health care accreditation and related services that support performance improvement in health care organization and is composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association.

Justice Involved (JI) Individuals means individuals who are currently incarcerated, or were formerly incarcerated within the past 12 months.

Knox-Keene Health Care Service Plan Act of 1975 (KKA) means the law that regulates health care service plans and is administrated by DMHC, commencing with H&S section 1340 *et seq*.

Laboratory Testing Site means any laboratory and any Provider site, such as a Primary Care Provider (PCP) or Specialist office or clinic, that performs tests or examinations on human biological specimens derived from the human body.

Licensed Midwife (LM) means an individual licensed to practice midwifery and assist a woman in normal childbirth as defined in California Business and Professions Code (B&P) section 2507.

Limited English Proficiency (LEP) means an inability or a limited ability to speak, read, write, or understand the English language at a level that permits the Member to interact effectively with Providers or Contractor's employees.

Local Educational Agency (LEA) means a school district, county office of education, charter school, community college district, California State University campus or University of California campus.

Local Government Agency (LGA) means a local governmental entity including, but not limited to, a county Child welfare agency, county probation department, county Behavioral Health department, county social services department, county public health department, school district, or county office of education.

Local Health Department (LHD) means a municipal, county, or regional public health department.

Long-Term Care (LTC) means specialized rehabilitative services and care provided in a Skilled Nursing Facility (SNF), subacute facility, pediatric subacute facility, Intermediate Care Facility/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), or ICF/DD-Nursing (ICF/DD-N) homes.

Long-Term Services & Supports (LTSS) means services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both Long-Term Care (LTC) and Home and Community-Based Services (HCBS) programs and includes carved-in and carved-out services.

Marketing means any activity conducted by or on behalf of Contractor where information regarding the services offered by Contractor is disseminated in order to persuade or influence Potential Members to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of Contractor.

Marketing Materials means materials produced in any medium, by or on behalf of Contractor that can be reasonably interpreted as Marketing to Potential Members. Marketing Materials include, but are not limited to, all printed materials, illustrated materials, digital materials, videos, and media scripts.

Marketing Representative means a person who is engaged in Marketing activities on behalf of Contractor.

Medi-Cal Eligibility Data System (MEDS) means the automated eligibility information processing system operated by DHCS which provides on-line access for Medi-Cal recipient information and update of Medi-Cal recipient eligibility data.

Medi-Cal FFS Rate means the rate that DHCS pays Providers on a per unit or per procedure billing code basis.

Medi-Cal Provider Manual means the multi-part document identifying Medi-Cal benefits and billing codes published and maintained by DHCS at https://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.aspx.

Medical Home means a model of organization of Primary Care that delivers the core functions of primary health care, which is comprised of comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety.

Medical Records means the record of a Member's medical information, including but not limited to medical history, care or treatments received, test results, diagnoses, and prescribed medications.

Medically Necessary or **Medical Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary. services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services

necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.

Member or **Enrollee** means a Potential Member who has enrolled with Contractor.

Member Assignment means the written notification and assignment of a Potential Member to the Medi-Cal managed care health plan of the Member's choice, or if as designated by DHCS when the Potential Member fails to make a timely choice.

Member Handbook or **Evidence of Coverage (EOC)** means the document that describes the health care benefits and Covered Services that are available to a Member.

Member Information means documents that are vital, or critical to obtaining benefits or services, and includes, but is not limited to: the Member Handbook, Provider Directory, welcome packets, Marketing information, form letters including Notice of Actions (NOA), notices related to Grievances or Appeals, including Grievance and Appeal acknowledgement and resolution letters, Contractor's preventive health reminders, Member surveys, notices advising of the availability of free language assistance, and newsletters.

Memorandum of Understanding (MOU) means a formal written agreement between Contractor and Local Government Agencies, county programs, and third-party entities.

Minimum Performance Level (MPL) refers to Contractor's minimum performance requirements for select Quality Performance Measures.

Minor Consent Services means those Covered Services of a sensitive nature which minors **may, without parental or guardian consent, receive.** ~~do not need~~ ~~parental consent to access, including~~ **Minor Consent Services include**, but **are** not limited to the following situations:

Under Age 12

A. Pregnancy and pregnancy related services

B. Family planning services

C. Sexual assault services

Age 12 and Older

D. Pregnancy and pregnancy related services

E. Family planning services

F. Sexual assault services

G. Infectious, contagious, or communicable disease diagnosis and treatment

H. Sexually transmitted diseases (or infections) prevention, diagnosis and treatment

I. Drug and alcohol abuse treatment and counseling

J. Outpatient mental health treatment and counseling

1) Minors may obtain outpatient mental health services, if the opinion of the attending professional person determines that the minor is mature enough to participate intelligently in their health care pursuant to Family Code section 6924.

K. Intimate partner violence services.

~~A. Sexual assault, including rape;~~

~~B. Drug or alcohol abuse for minors 12 years of age or older;~~

~~C. Pregnancy;~~

~~D. Family planning~~

~~E. Sexually transmitted diseases (STDs) in minors 12 years of age or older;~~

~~F. Diagnosis or treatment of infectious, contagious, or communicable diseases in minors 12 years of age or older if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer; and~~

~~G.~~ ~~Outpatient mental health care~~**.** ~~care for minors 12 years of age or older who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924~~**.**

Model of Care (MOC) means Contractor's approach for providing Enhanced Care Management (ECM) and Community Supports, including its Policies and Procedures for partnering with ECM and Community Supports Providers.

National Committee for Quality Assurance (NCQA) is an organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.

National Provider Identifier (NPI) means a unique identification number for Providers. Contractor must use the NPIs in the administrative and financial transactions adopted under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Network means Primary Care Providers (PCPs), Specialists, hospitals, ancillary Providers, facilities, and other Providers with whom Contractor enters into a Network Provider Agreement.

Network Provider means any Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.

Network Provider Agreement means a written agreement between a Network Provider and Contractor, Subcontractor, or Downstream Subcontractor.

Network Provider Data means information concerning all Network Providers in a Network, regardless of location, which render Covered Services to Members in a Contractor's Service Area and the provider groups, Subcontractors, and/or Downstream

Subcontractors, if any, under which a Network Provider renders those services. This includes, but is not limited to, information about the contractual relationship between Network Providers, provider groups, Subcontractors, and Downstream Subcontractors within the Network, information regarding the facilities where services are rendered, and information about a Network Provider's area(s) of specialization.

No Wrong Door means Members receive timely Behavioral Health Services without delay, regardless of delivery system where they seek care and are able to maintain treatment relationships with trusted Providers without interruption. This includes concurrent service provision, whereby Contractor must cover Medically Necessary Non-specialty Mental Health Services (NSMHS) for a Member concurrently receiving Specialty Mental Health Services (SMHS) covered by the county Mental Health Plan (MHP), and ensure those services are coordinated and not duplicative. Contractor must ensure compliance with No Wrong Door pursuant to W&I section 14184.402.

Non-Emergency Medical Transportation (NEMT) means ambulance, litter van, wheelchair van, and air medical transportation services. NEMT is used when the

Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, and pursuant to 22 CCR sections 51323, 51231.1, and 51231.2, is rendered by licensed Providers.

Non-Medical Transportation (NMT) means transportation of Members to obtain Covered Services or Excluded Services by passenger car, taxicabs, or other forms of public or private conveyances, and mileage reimbursement when conveyance is in a private vehicle arranged by the Member and not through a transportation broker, bus passes, taxi vouchers, or train tickets. NMT does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with State and local statutes, ordinances, or regulations.

Non-specialty Mental Health Services (NSMHS) means all of the following services that Contractor must provide when they are Medically Necessary, and is provided by PCPs or by licensed mental health Network Providers within their scope of practice:

A. Mental health evaluation and treatment, including individual, group and family psychotherapy;

B. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;

C. Outpatient services for the purposes of monitoring drug therapy;

D. Psychiatric consultation; and

E. Outpatient laboratory, drugs, supplies, and supplements, excluding separately billable psychiatric drugs claimed by outpatient pharmacy providers via Medi-Cal Rx.

Operations Period means the period of time between the effective date of the first month of operations and continues on through the last month of Contractor’s capitation and provision of services to Members. The Operations Period commences at the conclusion of the Implementation Period upon DHCS’ acceptance of Contractor’s completion of any readiness requirements required by DHCS.

Other Health Coverage (OHC) means health coverage from another entity that is responsible for payment of the reasonable value of all or part of the health care services provided to a Member. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member, excluding tort liability. OHC may originate under State (other than the Medi-

Cal program), federal, or local medical care program, or under other contractual or legal entitlements.

Partially Delegated Subcontractor means a Subcontractor that contractually assumes some, but not all, duties and obligations of Contractor under the Contract, including, for example, obligations regarding specific Member populations or obligations regarding a specific set of services. Individual physician associations and medical groups often operate as Partially Delegated Subcontractors.

Pass-Through Payment means the "Pass-through payment," as defined in 42 CFR section 438.6(a), that has been documented in a rate certification approved by the federal Centers for Medicare & Medicaid Services (CMS).

Phaseout Period means the period of time after the date the Operations Period or Contract extension ends. The Phaseout Period extends until all activities required during the Phaseout Period for each Service Area are fully completed.

Population Health Management (PHM) means a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses Member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized screening, assessment processes, and holistic care/case management interventions.

Population Health Management (PHM) Service (also known as Medi-Cal Connect) means a data backed platform that collects and links Medi-Cal beneficiary information from disparate sources and performs Risk Stratification and Segmentation (RSS) and Risk Tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions, and allows for multi-party data access and use in accordance with State and federal laws, regulations, and policies.

Population Health Management Strategy (PHMS) means an annual deliverable that Contractor must submit to DHCS requiring Contractor to demonstrate that it is responding to identified community needs, to provide other updates on its PHM program as requested by DHCS, and to inform the DHCS quality assurance and Population Health Management program compliance and impact monitoring efforts.

Population Needs Assessment (PNA) means a multi-year process during which Contractor will identify and respond to the needs of its Members and the communities it serves by participating in the Community Health Assessment (CHA) of Local Health Departments (LHDs) in its Service Area. The findings of the PNA/CHA collaboration will inform Contractor's annual PHM Strategy.

Post-Payment Recovery (PPR) means Contractor's efforts to recover the cost of the services from other third-party payors responsible for the payment of a Member's health care services.

Post-Stabilization Care Services means Covered Services related to an Emergency Medical Condition that are provided after a Member's condition is stabilized, in accordance with 42 CFR section 438.114 and 28 CCR section 1300.71.4, to improve or resolve the Member's condition.

Potential Member or **Potential Enrollee** means a Medi-Cal beneficiary who resides in Contractor's Service Area and is subject to mandatory Enrollment, or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan, and is in one of the following aid codes:

Aid Group	Mandatory Aid Codes	Non-Mandatory Aid Codes
Adult & Family/Optional Targeted Low-Income Child	01, 02, 08, 0A, 0E, 2V, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 5C, 5D, 5V, 72, 7A, 7J, 7S, 7W, 7X, 82, 86, 8E, 8P, 8R, 8U, E6, E7, **E8,** H1, H2, H3, H4, H5, K1, M3, M5, M7, M9, P5, P7, P9, R1, T1, T2, T3, T4, T5	03, 04, 06, 07, 2P, 2R, 2S, 2T, 2U, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4U, 4W, 5K, 5L, 76
Adult & Family/Optional Targeted Low-Income Child Dual Eligible	0A, 0E, 2C, 2V, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 5C, 5D, 5V, 72, 7A, 7J, 7S, 7W, 7X, 82, 8E, 8P, 8R, 8U, E6, E7, **E8,** H1, H2, H3, H4, H5, K1, M3, M5, M7, M9, P5, P7, P9, R1, T1, T2, T3, T4, T5	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4U, 4W, 5K, 5L
SPD Dual	10, 14, 16,1E, 1H, 1X, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 6X, L6	
SPD	10, 14, 16, 1E, 1H, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, L6	
Adult Expansion	L1, M1, 7U	

Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U, 0W	
Long-Term Care	13, 23, 53, 63	
Long-Term Care Dual	13, 23, 53, 63	

Prescription Drug means a drug or medication that can only be accessed through a Provider's prescription.

Preventive Care means health care designed to prevent disease, illness, injury, and/or its consequences.

Primary Care means health care usually rendered in ambulatory settings by Primary Care Providers (PCP) and mid-level practitioners that emphasizes the Member's general health needs as opposed to Specialists focusing on specific needs.

Primary Care Provider (PCP) means a Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Senior and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.

Prior Authorization means a formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.

Program Data means data that includes but is not limited to: Grievance data, Appeals data, medical exemption request denial reports and other continuity of care data, out-of-Network request data, and Primary Care Provider (PCP) assignment data as of the last calendar day of the reporting month.

Provider means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.

Provider Directory means Contractor's listing of all Network Providers and that includes the Providers' contact information, whether the Provider is accepting new Members, the hours of operation, what languages are available in the Provider's office and whether the Provider's office has accommodations, including offices, exam rooms and equipment, for people with physical disabilities.

Provider Dispute Resolution Mechanism means Contractor's obligation to include a timely, fair, and cost-effective dispute resolution process where Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers can submit disputes**.**

Provider-Preventable Condition (PPC) means a condition occurring in an inpatient hospital setting, or a condition occurring in any health care setting, that meets the criteria as stated in 42 CFR section 447.26(b).

Qualified Autism Services (QAS) Paraprofessional means an individual who is employed and supervised by a QAS Provider to provide Medically Necessary Behavioral Health Treatment (BHT) services to Members.

QAS Professional means an Associate Behavioral Analyst, Behavior Analyst, Behavior Management Assistant, or Behavior Management Consultant, as defined in the California Medicaid State Plan, who provides Medically Necessary Behavioral Health Treatment (BHT) services to Members.

QAS Provider means a licensed practitioner or Board-Certified Behavior Analyst (BCBA) who designs, supervises, or provides Medically Necessary Behavioral Health Treatment (BHT) services to Members.

Quality Improvement (QI) means systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.

Quality Improvement and Health Equity Committee (QIHEC) means a committee facilitated by Contractor's medical director, or the medical director's designee, in collaboration with the Health Equity officer that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.

Quality Improvement and Health Equity Transformation Program (QIHETP) means the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and this Contract.

Quality Measure Compliance Audit means a thorough assessment of Contractor's information system capabilities and compliance with each Healthcare Effectiveness Data and Information Set (HEDIS®) specification to ensure accurate, reliable, and publicly reportable data.

Quality of Care means the degree to which health services for Members increase the likelihood of desired health outcomes and are consistent with current professional standards of care and knowledge.

Quality Performance Measures means tools that help measure healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are

associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.

Quantitative Treatment Limitation (QTL) means a limit on the scope or duration of a Covered Service that is expressed numerically.

Rating Period means a period selected by DHCS for which actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR section 438.7(a).

Regional Center (RC) means a non-profit, community-based entity that is contracted by Department of Developmental Services (DDS) and develops, purchases, and manages services for Members with Developmental Disabilities and their families.

Restricted Provider Database (RPD) means the database maintained by DHCS that lists Providers who are placed under a Medi-Cal payment suspension while under investigation based upon a credible allegation of Fraud, or Providers who are placed on a temporary or indefinite Medi-Cal suspension while under investigation for Fraud or Abuse, or Enrollment violations.

Retrospective Review means the process of determining Medical Necessity after treatment has been given.

Risk Sharing Mechanism means any payment arrangement, such as reinsurance, risk corridors, or stop-loss limits, documented in the CMS-approved rate certification documents for the applicable Rating Period prior to the start of the Rating Period, that is developed in accordance with 42 CFR section 438.4, the rate development standards in 42 CFR section 438.5, and generally accepted actuarial principles and practices.

Risk Stratification and Segmentation (RSS) means the process of separating Member populations into different risk groups and/or meaningful subsets, using information collected through population assessments and other data sources. RSS results in the categorization of Members with care needs at all levels and intensities.

Risk Tiering means the assigning of Members to standard Risk Tiers (low, medium-rising, or high), with the goal of determining appropriate care management programs or specific services.

Rural Health Clinic (RHC) means an entity defined in 42 USC section 1395x(aa)(2) to provide Primary Care and ambulatory services.

Safety-Net Provider means any Provider of comprehensive Primary Care or acute hospital inpatient services that provides services to a significant number of Medi-Cal

recipients, patients who receives charity, and/or patients who are medically underinsured, in relation to the total number of patients served by the Provider.

School Site means a facility or location used for public kindergarten, elementary, secondary, or postsecondary purposes. “School Site” also includes a location not owned or operated by a public school, or public school district, if the school or school district provides or arranges for the provision of Medically Necessary treatment of a mental health or Substance Use Disorder to its students at that location, including off-campus clinics, mobile counseling services, and similar locations.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services means comprehensive, integrated delivery of early intervention and treatment services for Members with Substance Use Disorders (SUD), as well as those who are at risk of developing SUDs.

Senior and Person with Disability (SPD) means a Member who falls under a specific SPD aid code as defined by DHCS.

Service Area means the county or counties that Contractor is approved to operate in under the terms of this Contract. A Service Area may be limited to designated zip codes (under the U.S. Postal Service) within a county.

Service Location means the location where a Member obtains Covered Services under the terms of this Contract.

Significant Change means changes in Covered Services, benefits, geographic Service Area, composition of payments to its Network, or Enrollment of a new population.

Site Review means surveys and reviews conducted by DHCS or Contractor to ensure that Network Provider, Subcontractor, and Downstream Subcontractor sites have sufficient capacity to provide appropriate health care services, carry out processes that support continuity and coordination of care, maintain Member safety standards and practices, and operate in compliance with all applicable federal, State, and local laws and regulations.

Skilled Nursing Care means Covered Services provided by nurses, technicians, and/or therapists during a stay in a Skilled Nursing Facility or in a Member’s home.

Skilled Nursing Facility (SNF) means any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital

Back to Agenda Back to Item

does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal program.

Social Drivers of Health (SDOH) means the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk. Also known as Health Related Social Needs.

Special Care Center means a center that provides comprehensive, coordinated health care to California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) clients with specific medical conditions.

Specialist means a Provider who has completed advanced education and clinical training in a specific area of medicine or surgery. Specialists include, but are not limited to, those Specialists listed in W&I section 14197.

Specialty Mental Health Provider means a person or entity who is licensed, certified, otherwise recognized, or authorized under the California law governing the healing arts and who meets the standards for participation in the Medi-Cal program to provide Specialty Mental Health Services.

Specialty Mental Health Service (SMHS) means a Medi-Cal covered mental health service provided or arranged by county mental health plans for Members in their counties that need Medically Necessary Specialty Mental Health Services.

Standing Referral means a referral by a Primary Care Provider (PCP) to a Specialist for more than one visit to the Specialist, as indicated in the treatment plan, if any, without the Primary Care Provider having to provide a specific referral for each visit.

State means the State of California.

State Hearing means a hearing with a State Administrative Law Judge to resolve a Member's dispute about an action taken by Contractor, its Network Providers, Subcontractors, or Downstream Subcontractors.

State Supported Services means Medi-Cal services that are funded entirely by the State, and for which the State does not receive matching federal funds. These services are covered by Contractor through their Secondary Contract with DHCS for State Supported Services.

Street Medicine means a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment that Contractor may offer to their Members. The fundamental approach of Street Medicine is to engage people experiencing unsheltered homelessness exactly where they are and on their

own terms to maximally reduce or eliminate barriers to care access and follow-through. Street Medicine utilizes a whole person, patient-centered approach to provide Medically Necessary health care services, as well as address Social Drivers of Health that impede health care access.

Street Medicine Provider means a Provider that renders Street Medicine services as offered by Contractor to their Members. Street Medicine Providers may provide services in various roles, such as the Member's assigned Primary Care Provider (PCP), through a direct contract with the Contractor, as an Enhanced Care Managed (ECM) Provider, as a Community Supports Provider, or as a referring or treating contracted Provider as set forth in APL 24-001.

Subacute Care means a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed Skilled Nursing Care than is provided to the majority of Members in a Skilled Nursing Facility (SNF), as defined in 22 CCR section 51124.5.

Subcontractor means an individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

Subcontractor Agreement means a written agreement between Contractor and a Subcontractor. The Subcontractor Agreement must include a delegation of Contractor's duties and obligations under the Contract.

Subcontractor Network means a Network of a Subcontractor or Downstream Subcontractor, wherein the Subcontractor or Downstream Subcontractor is delegated risk and is responsible for arranging for the provision of and paying for Covered Services as stated in their Subcontractor or Downstream Subcontractor Agreement.

Substance Use Disorder (SUD) means those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

Supplemental Payment means a payment, in addition to the Capitation Payment, made by DHCS to Contractor in accordance with Exhibit B, Section 1.7 (*Supplemental Payments*) of this Contract.

Suspended and Ineligible Provider List means the list containing the names of former Medi-Cal Providers suspended from or ineligible for participation in the Medi-Cal program. The Suspended and Ineligible Provider List is available online at https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx.

Targeted Case Management (TCM) means services which assist Members within specified target groups to gain access to needed medical, social, educational, and other services, as set forth in 42 USC section 1396n(g). In prescribed circumstances, TCM is available as a Medi-Cal benefit and a discrete service through State or local government entities and their contractors.

Telehealth means a method of delivering health care services by using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at a separate location from the Provider.

Template Data means data reports submitted to DHCS by Contractors, which includes, but is not limited to, data of Member populations, health care benefit categories, or program initiatives.

Third Party Tort Liability (TPTL) means the contractual responsibility or tort liability of an individual or entity other than Contractor or the Member for the payment of claims for injuries, or trauma sustained by a Member.

Threshold Languages/Threshold or Concentration Standard Languages means the non-English threshold and concentration standard languages in which Contractor is required to provide written translations of Member Information, as determined by DHCS.

Transitional Care Service means a service provided to all Members transferring from one institutional care setting, or level of care, to another institution or lower level of care, including home settings.

Treatment Authorization Request (TAR) means certain Fee-For-Service (FFS) procedures and services that are subject to authorization by Medi-Cal field offices before reimbursement can be approved.

Tribal Federally Qualified Health Center (Tribal FQHC) means a Tribal Health Program funded under the authority of Public Law 93-638 at 25 USC sections 5301 et seq. These Health Programs have elected to participate in Medi-Cal Tribal FQHCs and are subject to the payment terms of APL 21-008. Reimbursement of Tribal FQHCs is through an Alternative Payment Methodology (APM), which is set at the federal Indian Health Service All-Inclusive Rate. The APM rate is updated annually and published in APL 21-008, Attachment #1. A list of Tribal FQHCs is published in APL 21-008, Attachment #2.

Tribal Health Program means an American Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service through, or provided for in, a contract or compact with the Indian Health Service under the Indian Health Service under the Indian Self-

Determination and Education Assistance Act and is defined in 25 USC section 1603(25).

United States Department of Health and Human Services (U.S. DHHS) means the federal agency that oversees Centers for Medicare & Medicaid Services (CMS) that works in partnership with state governments to administer the Medicaid program, the Children's Health Insurance Program (CHIP), and health insurance portability standards.

Urban Indian Organization means a nonprofit corporate body situated in an urban center, governed by an urban American Indian controlled board of directors, as defined in 25 USC section 1603(29). Urban Indian Organizations participate in Medi-Cal as Tribal Federally Qualified Health Centers (Tribal FQHCs) or community clinics and are reimbursed via the Prospective Payment System or at Fee-For-Service rates.

Urgent Care means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.

Utilization Management (UM) or **Utilization Review** means the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

Vaccines for Children (VFC) Program means the federally funded program that provides free vaccines for eligible Children age 18 or younger (including all Medi-Cal eligible Children age 18 or younger) and distributes immunization updates and related information to participating Providers.

Waste means the overutilization or inappropriate utilization of services and misuse of resources.

Withhold Arrangement means any payment mechanism approved by the Centers for Medicare & Medicaid Services (CMS) in accordance with the requirements of 42 CFR section 438.6(b) under which a portion of a capitation rate is withheld from Contractor, with a portion or all of the withheld amount to be paid to Contractor for meeting targets specified in this Contract, including but not limited to Exhibit B, Subsection 1.1.14.E (*Special Contract Provisions Related to Payment*).

Working Capital Ratio means a liquidity ratio, calculated as current assets divided by current liabilities, that measures Contractor’s ability to pay its current liabilities with current assets. Working Capital Ratio is computed in accordance with Generally Accepted Accounting Principles (GAAP).

Working Day(s) means Monday through Friday, except for State holidays as identified at the California Department of Human Resources State Holidays page.

"Your Rights" Attachment means Contractor's written notice sent to the Member that explains the Member's rights to challenge, free of charge, Contractor's action, and the Member's right to file an Appeal with Contractor, a Deemed Exhaustion, and the right to request a State Hearing or an Independent Medical Review (IMR).

2.0 Acronyms

Medi-Cal Managed Care Contract Acronyms List

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following acronyms are abbreviations for the corresponding terms. This Acronyms List is provided for the convenience of the parties and must not be deemed as an exhaustive or exclusive list of all acronyms in this Contract. In the event that the acronyms contained in this list are inconsistent with the provisions in the Contract, the Contract provisions will prevail.

Acronyms	Corresponding Terms
AAP	American Academy of Pediatrics
ABD	Adverse Benefit Determination
ACE	Adverse Childhood Experience
ACIP	Advisory Committee on Immunization Practices
ACOG	American College of Obstetrician and Gynecologists
ADA	Americans with Disabilities Act of 1990
ADHC	Adult Day Health Care
ADL	Activity of Daily Living
ADO	Alternate Dispute Officer
ADT	Admission, Discharge, and Transfer
AFS	Alternative Format Selection
AIDS	Acquired Immune Deficiency Syndrome
APL	All Plan Letter
API	Application Programming Interface
APS	Asthma Preventive Service
AR	Authorized Representative
ASAM	American Society of Addiction Medicine
ASD	Autism Spectrum Disorder
Basic PHM	Basic Population Health Management
BHT	Behavioral Health Treatment
C&L	Cultural & Linguistic
CalAIM	California Advancing and Innovating Medi-Cal
CBAS	Community Based Adult Services
CB-CME	Community-Based Care Management Entities
CCM	Complex Care Management
CCR	California Code of Regulations
CCS	California Children's Services
CDPH	California Department of Public Health
CFR	Code of Federal Regulations

Acronyms	Corresponding Terms
CHA	Community Health Assessment
CHIP	Community Health Implementation Plan
CHSP	Children's Hospital Supplemental Payment
CHW	Community Health Worker
CLIA	Clinical Laboratory Improvement Act
CLPPB	Childhood Lead Poisoning Prevention Branch
CMP	Care Management Plan
CMS	The Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
COBA	Coordination of Benefits Agreement
COHS	County Organized Health Systems
CPSP	Comprehensive Perinatal Services Program
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
CRC	Caregiver Resource Center
CYSHCN	Children and Youth with Special Health Care Needs
DDS	Department of Developmental Services
DF	Disclosure Form
DHCS	Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DME	Durable Medical Equipment
DMFEA	Office of the Attorney General, Division of Medi-Cal Fraud and Elder Abuse
DMHC	Department of Managed Health Care
DOT	Direct Observed Therapy
D-SNP	Dual-Eligible Special Needs Plan
DUR	Drug Use Review
DVBE	Disabled Veteran Business Enterprises
ECM	Enhanced Care Management
EMT	Emergency Medical Transportation
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ERS	CBAS Emergency Remote Services
FBC	Freestanding Birthing Centers
FDA	United States Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee-For-Service

Acronyms	Corresponding Terms
FQHC	Federally Qualified Health Center
FSR	Facility Site Review
GAAP	Generally Accepted Accounting Principles
GC	California Government Code
H&S	Health and Safety Code
HCBS	Home and Community-Based Services
HCO	Health Care Options
HCPCS	Healthcare Common Procedure Coding System
HEDIS®	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	The Health Insurance Portability and Accountability Act of 1996
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HPA	Health Plan Accreditation
HUD	The United States Department of Housing and Urban Development
IADL	Instrumental Activity of Daily Living
ICD-10	International Classification of Diseases, Tenth Revision
ICF	Intermediate Care Facility
ICF/DD	Intermediate Care Facility Developmentally Disabled
ICF/DD-H	Intermediate Care Facility/Developmentally Disabled Habilitative
ICF/DD-N	Intermediate Care Facility/Developmentally Disabled Nursing
IEP	Individualized Education Plan
IFSP	Individualized Family Service Plan
IHA	Initial Health Appointment
IHCP	Indian Health Care Provider
IHS	Indian Health Service
IHSP	Individualized Health and Support Plan
IHSS	In-Home Supportive Services
IMD	Institution for Mental Diseases
IMR	Independent Medical Review
IPA	Independent Physician/Provider Associations
IPC	Individual Plan of Care
IT	Information Technology
JC	Joint Commission
JI	Justice Involved
KKA	Knox-Keene Health Care Service Plan Act of 1975

Acronyms	Corresponding Terms
LEA	Local Education Agency
LEP	Limited English Proficiency
LGA	Local Government Agency
LHD	Local Health Department
LM	Licensed Midwife
LTC	Long-Term Care
LTSS	Long-Term Services and Support
MAT	Medications for Addiction Treatment (or Medication-Assisted Treatment)
MCH	Maternal and Child Health
MEDS	Medi-Cal Eligibility Data System
MFTP	Money Follows the Person
MHP	County Mental Health Plan
MIS	Management and Information System
MLR	Medical Loss Ratio
MOC	Model of Care
MOU	Memorandum of Understanding
MPL	Minimum Performance Level
MSSP	Multipurpose Senior Service Program
NABD	Notice of Adverse Benefit Determination
NAR	Notice of Appeal Resolution
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NEMT	Non-Emergency Medical Transportation
NISTSP	National Institute of Standards and Technology Special Publication
NMT	Non-Medical Transportation
NOA	Notice of Action
NP	Nurse Practitioner
NPI	National Provider Identifier
NQTL	Non-Quantitative Treatment Limitation
NSMHS	Non-specialty Mental Health Service
OHC	Other Health Coverage
PACE	Program for All-Inclusive Care for the Elderly
PCC	California Public Contract Code
PCP	Primary Care Provider
PHI	Protected Health Information
PHM	Population Health Management
PHMS	Population Health Management Strategy

Acronyms	Corresponding Terms
PI	Personal Information
PIA	Prison Industry Authority
PIP	Performance Improvement Project
PIR	Privacy Incident Reporting
PIU	Program Integrity Unit
PL	Policy Letter
PNA	Population Needs Assessment
PPC	Provider-Preventable Condition
PPR	Post-Payment Recovery
PSCI	Personal, Sensitive, and/or Confidential Information
QAS	Qualified Autism Services
QI	Quality Improvement
QIHEC	Quality Improvement and Health Equity Committee
QIHETP	Quality Improvement and Health Equity Transformation Program
QSO	Qualified Service Organization
QTL	Quantitative Treatment Limitation
RC	Regional Center
RHC	Rural Health Clinic
RPD	Restricted Provider Database
RSS	Risk Stratification and Segmentation
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDOH	Social Drivers of Health
SED	Serious Emotional Disturbance
SFTP	Secure File Transfer Protocol
SMHS	Specialty Mental Health Services
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SPD	Senior and Person with Disability
STC	Special Terms and Conditions
STD	Sexually Transmitted Disease
SUD	Substance Use Disorder
TAR	Treatment Authorization Request
TB	Tuberculosis
TCM	Targeted Case Management
TDD	Telecommunication Devices for the Deaf
TNE	Tangible Net Equity
TPTL	Third Party Tort Liability
TTY	Telephone Typewriters

Acronyms	Corresponding Terms
U.S. DHHS	United States Department of Health and Human Services
UM	Utilization Management
US DOJ	United States Department of Justice
USC	United States Code
USPSTF	United States Preventive Services Task Force
VFC	Vaccines for Children
W&I	Welfare and Institutions Code
WCM	Whole Child Model
WIC	Women, Infants and Children Supplemental Nutrition Program

Exhibit A, ATTACHMENT II

1.0 Operational Readiness Deliverables and Requirements

This Article describes a non-exhaustive list of Contractor deliverables, activities, and timeframes to be completed during the Implementation Period before beginning the Operations Period.

Upon successful completion of operational readiness deliverables and requirements, DHCS will provide Contractor a written authorization to begin its Operations Period. The Implementation Period begins with the effective date of the Contract and extends to the beginning of the Operations Period.

Once the Contract is awarded, DHCS will provide Contractor with a timeline to complete Implementation Period deliverables and requirements. The table in this Article must not be deemed as exhaustive, exclusive, or limiting. Contractor must submit all required operational deliverables consistent with all requirements set forth in this Contract on a schedule, form, and manner specified by the DHCS. Contractor may be responsible for additional deliverable requirements or activities during the Implementation Period based on changes in State and federal law and/or DHCS program needs. Contractor must comply with any additional requirements, not listed in the tables below, upon DHCS' request and in the form and manner specified by DHCS.

In the event Contractor fails to submit all deliverables in accordance with the milestones and timeframes required by DHCS, DHCS may impose Liquidated Damages and Sanctions in accordance with Exhibit E, Sections 1.1.19 (*Sanctions*) and 1.20 (*Liquidated Damages*).

Dual Special Needs Plan

Contractors located in counties that had previously participated in the Coordinated Care Initiative (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties) must have a Dual Special Needs Plan (D-SNP) available to dual eligible Members for contract year 2024 and 2025 and must have documentation of the Centers for Medicare & Medicaid approval of the D-SNP by December 2, 2023.

EXHIBIT A, ATTACHMENT I – 1.0 DEFINITIONS

No deliverables listed for this Article.

EXHIBIT A, ATTACHMENT I – 2.0 ACRONYMS

No deliverables listed for this Article.

EXHIBIT A, ATTACHMENT II –1.0 OPERATIONAL READINESS DELIVERABLES AND REQUIREMENTS

See specific contract Sections below for details.

EXHIBIT A, ATTACHMENT III – 1.1 PLAN ORGANIZATION AND ADMINISTRATION

Identifier	Operational Readiness Requirement
R.0001	Submit documentation of State employees (current and former) who may present a conflict of interest as defined in Exhibit A, Attachment III, Subsection 1.1.3 (*Conflict of Interest – Current and Former State Employees)*.
R.0002	Submit a complete organizational chart.
R.0003	If Contractor is a subsidiary organization, submit an attestation by the parent organization that this Contract will be a high priority to the parent organization.
R.0004	Submit an attestation that the medical decisions made by the medical director will not be unduly influenced by fiscal or administrative management.
R.0005	Submit policies and procedures describing the representation and participation of Medi-Cal Members on Contractor's public policy advisory committee.
R.0006	Submit the Knox-Keene license exhibits and forms reflecting current operation status, as specified in Exhibit A, Attachment III, Section 1.1 (*Plan Organization and Administration*) and 28 California Code of Regulations (CCR) section 1300.51.
R.0007	Submit supporting documentation if Contractor is not currently licensed to operate in an awarded Service Area, as specified in Exhibit A, Attachment III, Section 1.1 (*Plan Organization and Administration*).
R.0008	If, within the last five years, Contractor has had a contract terminated or not renewed for poor performance, nonperformance, or any other reason, Contractor must submit a summary of the circumstances surrounding the termination or non-renewal, a description of the parties involved, including address(es) and telephone number(s). Describe Contractor's Corrective Actions to prevent future occurrences of any problems identified.
R.0009	Identify the composition and meeting frequency of any committee participating in establishing Contractor's public policy including the percent of patient/Member consumers. Describe Contractor's Governing Board, including the percent of patient/Member consumers, the frequency of the committee's report submission to Contractor's Governing Board, and the Governing Board's process for handling reports and recommendations after receipt.

Identifier	Operational Readiness Requirement
R.0010	Contractor must submit policies and procedures for ensuring that all appropriate staff and Network Providers receives annual diversity, Health Equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency/humility training) relating to Members including completion of required Continuing Medical Education on cultural competency/humility and implicit bias.

EXHIBIT A, ATTACHMENT III – 1.2 FINANCIAL INFORMATION

Identifier	Operational Readiness Requirement
R.0012	Submit most recent audited annual financial reports.
R.0013	Submit quarterly Financial Statements with the most recent quarter prior to execution of the Contract.
R.0014	Submit the Knox-Keene license exhibits reflecting projected financial viability as specified in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and 28 CCR section 1300.76.
R.0015	Submit Knox-Keene license Exhibit HH-6 as specified in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and 28 CCR section 1300.51(d)(HH).
R.0016	1) Describe any risk sharing or Incentive Arrangements. 2) Explain any intent to enter into a stop loss option with DHCS. 3) Describe any reinsurance and risk-sharing arrangements with any Subcontractors and Downstream Subcontractors shown in this Contract. 4) Submit copies of all policies and agreements. 5) Comply with assumption of financial risk and reinsurance requirements pursuant to 22 CCR sections 53863 and 53868. Comply with directed payments requirements pursuant to 42 Code of Federal Regulations (CFR) section 438.6.
R.0017	Fiscal Arrangements: Submit the Knox-Keene license exhibits as described in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and in 28 CCR section 1300.51.
R.0018	Describe systems for ensuring that Subcontractors, Downstream Subcontractors, and Network Providers who are providing services to Medi-Cal Members, have the administrative and financial capacity to meet its contractual obligations and requirements, as described in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and in 22 CCR section 53250 and 28 CCR section 1300.70.

Identifier	Operational Readiness Requirement
R.0019	Submit financial policies that relate to Contractor's systems for budgeting and operations forecasting. The policies should include comparison of actual operations to budgeted operations, timelines used in the budgetary process, number of years prospective forecasting is performed, and variance analysis and follow-up procedures.
R.0020	Describe process to ensure timely filing of required financial reports as described in Exhibit A, Attachment III, Section 1.2 (*Financial Information*). Contractor must also describe how it will comply with the Administrative Cost requirements referenced in 22 CCR section 53864(b).
R.0021	Provide letters of financial support, credit, bond, or loan guarantee or other financial guarantees, if any, in at least the same amount that the obligations to Members will be performed.

EXHIBIT A, ATTACHMENT III – 1.3 PROGRAM INTEGRITY AND COMPLIANCE PROGRAM

Identifier	Operational Readiness Requirement
R.0022	Submit a Compliance Program, Standard of conduct or code of conduct, related policies and procedures, and training materials.
R.0023	Organizational chart for the Compliance Program showing key personnel.
R.0024	Submit a Fraud Prevention Program and related policies and procedures, training materials, and an organizational chart showing key personnel.
R.0025	Submit policies and procedures for the screening, Enrollment of Network Providers, if Contractor elects to screen and enroll.

EXHIBIT A, ATTACHMENT III – 2.1 MANAGEMENT INFORMATION SYSTEM

Identifier	Operational Readiness Requirement
R.0026	Submit a completed MCO Baseline Assessment Form.

Identifier	Operational Readiness Requirement
R.0027	If procuring a new Management and Information System (MIS) or modifying a current system, Contractor must provide a detailed implementation plan that includes the following: 1) Outline of the tasks required; 2) The major milestones; and 3) The responsible party for all related tasks. In addition, the implementation plan must also include: 1) A full description of the acquisition of software and hardware, including the schedule for implementation; 2) Full documentation of support for software and hardware by the manufacturer or other contracted party; 3) System test flows through a documented process that has specific control points where evaluation data can be utilized to correct any deviations from expected results; and 4) Documentation of system changes related to Exhibit G, (*Business Associate Addendum*) requirements.
R.0028	Submit a detailed description, including a diagram and/or flow chart, of how Contractor will monitor the flow of Encounter Data, Network Provider Data, Program Data, Template Data, and all other data required by this Contract from origination at the Provider level to Contractor, through submission to DHCS as well as how Contractor will transmit information regarding general and specific data quality issues identified by DHCS from origination to Providers for correction.
R.0029	Submit Encounter Data, Provider data, Program Data, and Template Data test files as required by DHCS, produced using real or proxy data processed by a new or modified MIS to DHCS. Production data submissions from a new or modified MIS may not take place until this test has been successfully reviewed and approved by DHCS.
R.0030	Submit policies and procedures for the submission of complete, accurate, reasonable and timely Encounter Data, Provider data, Program Data, Template Data, and all other data required by this Contract, including how Contractor will correct data quality issues identified by DHCS.
R.0032	Submit the data security, backup, or other data disaster processes used in the event of a MIS failure.
R.0033	Submit a detailed description, including details regarding interoperability, of the proposed and/or existing MIS as it relates to each of the subsystems described in Exhibit A, Attachment III, Section 2.1 (*Management Information System*).

Back to Agenda Back to Item

Identifier	Operational Readiness Requirement
R.0246	Submit policies and procedures to demonstrate how Contractor will conduct routine testing and monitoring, and update their systems as appropriate to ensure the Application Programming Interfaces (APIs) are functioning properly and complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements.

EXHIBIT A, ATTACHMENT III – 2.2 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

Identifier	Operational Readiness Requirement
R.0035	Submit a flow chart and/or organization chart identifying all components of the Quality Improvement and Health Equity Transformation Program (QIHETP) including who is involved and responsible for each activity.
R.0036	Submit a flow chart and/or organization chart identifying all components of the QIHETP including who is involved and responsible for each activity, for each Fully Delegated Subcontractor, and each health plan downstream Subcontractor.
R.0037	Submit policies that specify the responsibility of the Governing Board in the QIHETP.
R.0038	Submit policies for the Quality Improvement and Health Equity Committee (QIHEC) including membership, activities, roles and responsibilities and reporting relationships to other committees within the organization.
R.0039	Submit policies for each Fully Delegated Subcontractor's and health plan Downstream Subcontractor's QIHEC including membership, activities, roles and responsibilities, and reporting relationships to other committees within the organization.
R.0040	Submit procedures outlining how Providers, health plan Subcontractors, and health plan Downstream Subcontractors will participate in the QIHETP and Population Needs Assessment (PNA) and how the findings from both will be shared with Providers, health plan Subcontractors and health plan Downstream Subcontractors.
R.0041	Submit policies and procedures related to the oversight of Subcontractors and Downstream Subcontractors for any delegated QIHETP activities, including a complete list of all Subcontractors, Downstream Subcontractors, and their delegated QIHETP activities.
R.0042	Submit policies and procedures that describe how Contractor will develop and submit an annual QIHETP Plan that provides a comprehensive assessment of all Quality Improvement (QI) and Health Equity activities undertaken, including an evaluation of the effectiveness of QI and Health Equity interventions, and an assessment of all Subcontractors' performance for any delegated QI and/or Health Equity activities.

Identifier	Operational Readiness Requirement
R.0043	Submit policies and procedures to address how Contractor will meet each of the following requirements: 1) Quality and Health Equity Performance Measure annual reporting requirements; 2) Meet or exceed DHCS established Quality and Health Equity Performance measure benchmarks; 3) Ensure all Fully Delegated Subcontractors meet or exceed DHCS established Quality and Health Equity Performance measure benchmarks; 4) Performance Improvement Projects; 5) Consumer Satisfaction Survey; 6) Network Adequacy Validation; 7) Encounter Data Validation; 8) Focused Studies; and 9) Technical Assistance Recommendations.
R.0044	Submit policies and procedures for reporting any disease or condition to public health authorities.
R.0045	Submit policies and procedures for Credentialing and recredentialing that ensure all Network Providers who deliver Covered Services to Members are qualified in accordance with applicable standards and are licensed, certified, or registered, as appropriate.
R.0046	No later than January 1, 2024, submit either (A) or (B and C): A. Evidence of National Committee for Quality Assurance (NCQA) Health Plan Accreditation. B. Timeline that demonstrates the NCQA Health Plan Accreditation process will be started no later than January 1, 2024, and full NCQA Health Plan Accreditation will be received no later than January 1, 2026. C. Evidence of interim NCQA Health Plan Accreditation approval within five Working Days of receipt.
R.0047	No later than January 1, 2024, submit either (A) or (B): A. Evidence of NCQA Health Equity Accreditation. B. Timeline that demonstrates the NCQA Health Equity Accreditation process will be started no later than January 1, 2024, and completed no later than January 1, 2026.
R.0048	Submit policies and procedures for identifying, evaluating, and reducing Health Disparities.
R.0049	Submit policies and procedures that describe how Contractor ensures the adoption, dissemination and monitoring of the use of clinical practice guidelines.
R.0050	Submit policies and procedures that describe the integration of Utilization Management into the QIHETP.

Identifier	Operational Readiness Requirement
R.0051	Submit policies and procedures that describe how Contractor will detect both over- and under-utilization of services, including outpatient Prescription Drugs.
R.0052	Submit policies and procedures that describe how Contractor will ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services provided for Members less than 21 years of age, and how Contractor will identify and address underutilization of preventive services for such Members.
R.0053	Submit policies and procedures that describe how Contractor will promote Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and preventive services to Members less than 21 years of age, as well as outreach to Members less than 21 years of age overdue for such services.
R.0055	Submit a description of a comprehensive wellness program for Members less than 21 years of age.
R.0056	Submit policies and procedures that describe how Contractor will maintain and continually monitor, evaluate, and improve Cultural and Linguistic (C&L) services that support the delivery of Covered Services to Members less than 21 years of age.
R.0057	Submit policies and procedures that describe how Contractor will develop and maintain a school-linked statewide Network of School Site Behavioral Health counselors.
R.0058	Submit policies and procedures that describe how Contractor will inform its Network Providers about the Vaccines for Children (VFC) program and how they will promote and support Enrollment of appropriate Providers in VFC.
R.0059	Submit policies and procedures that describe Contractor's Member and family engagement strategy and how Members and/or parents and caregivers are engaged in the development of QI and Health Equity activities and interventions.
R.0060	Submit policies and procedures that describe how Contractor will engage with local entities when developing interventions and strategies to address deficiencies in performance measures related to Members less than 21 years of age.
R.0061	Submit policies and procedures that describe how Contractor will ensure the provision of all Medically Necessary mental health and Substance Use Disorder (SUD) services to Members less than 21 years of age.

EXHIBIT A, ATTACHMENT III – 2.3 UTILIZATION MANAGEMENT PROGRAM

Identifier	Operational Readiness Requirement
R.0062	Submit written description of Utilization Management (UM) program that describes appropriate processes to be used to review, approve, modify, deny, and delay the provision of medical, mental health, and SUD services to demonstrate compliance with mental health parity.
R.0063	Submit written description of procedures for reviews and annual updates of UM program.
R.0064	Submit written description of Grievances and Appeals procedures for Providers and Members that will be published on Contractor's website.
R.0065	Submit policies and procedures for Standing Referrals.
R.0066	Submit policies and procedures on Standing Referrals when a Member condition requires a specialized medical care over a prolonged period of time.
R.0067	Submit policies and procedures for Prior Authorization, concurrent review, and Retrospective Review.
R.0068	Submit a list of services requiring Prior Authorization and the Utilization Review criteria.
R.0069	Submit policies and procedures for the Utilization Review Appeals process for Providers and Members.
R.0070	Submit policies and procedures that specify timeframes for medical authorization.
R.0072	Submit policies and procedures to detect both under- and over-utilization of health care services.
R.0073	Submit policies and procedures showing how UM functions which may be delegated to a Subcontractor or Downstream Subcontractor will be regularly evaluated for compliance with Contract requirements and, that any issues identified through the UM program are appropriately resolved; and that UM activities are properly documented and reported.
R.0074	Submit policies and procedures to refer Members who are potentially eligible for Multipurpose Senior Service Program (MSSP) services to MSSP services Providers for authorization.

EXHIBIT A, ATTACHMENT III – 3.1 NETWORK PROVIDER AGREEMENTS, SUBCONTRACTOR AGREEMENTS, DOWNSTREAM SUBCONTRACTOR AGREEMENTS, AND CONTRACTOR'S OVERSIGHT DUTIES

Identifier	Operational Readiness Requirement
R.0075	Submit policies and procedures for a system to evaluate and monitor the financial viability of all Network Providers, Subcontractors, and Downstream Subcontractors.
R.0076	Submit executed Network Provider Agreements/Subcontractor Agreements/Downstream Subcontractor Agreements or documentation substantiating Contractor's efforts to enter into these agreements with the Local Health Department (LHD) for each of the following public health services: 1) Family Planning Services; 2) Sexually Transmitted Disease (STD) Services; 3) Human Immunodeficiency Virus (HIV) testing and counseling; and 4) Immunizations.
R.0244	Submit all Network Provider, Subcontractor, and Downstream Subcontractor Agreements templates.
R.0245	Submit Subcontractor and Downstream Subcontractor Agreement templates language showing accountability of any delegated QIHETP functions and responsibilities.

EXHIBIT A, ATTACHMENT III – 3.2 PROVIDER RELATIONS

Identifier	Operational Readiness Requirement
R.0077	Submit policies and procedures for the Provider Dispute Resolution Mechanism.
R.0078	Submit a written description of how Contractor will communicate the Provider Dispute Resolution Mechanism to Network Providers, out-of-Network Providers, Subcontractors, and Downstream Subcontractors.
R.0079	Submit protocols for payment and communication with out-of-Network Providers.
R.0080	Submit policies and procedures for ensuring out-of-Network Providers receive Contractor's clinical protocols and evidence-based practice guidelines.
R.0081	Submit copy of Contractor's Provider manual.
R.0082	Submit a schedule of Network Provider training to be conducted during year one of operation. Include date, time and location, and complete curriculum.

Identifier	Operational Readiness Requirement
R.0083	Submit policies and procedures for ensuring Network Providers receive training within the required timeframes, regarding clinical protocols, evidenced-based practice guidelines, and DHCS developed cultural awareness and sensitivity instruction for Senior and Person with Disability (SPD) Members.
R.0084	Submit protocols for communicating and interacting with emergency departments in and out of Contractor's Service Area.

EXHIBIT A, ATTACHMENT III – 3.3 PROVIDER COMPENSATION ARRANGEMENTS

Identifier	Operational Readiness Requirement
R.0085	Submit policies and procedures regarding timing of Capitation Payments to Primary Care Providers (PCP) or clinics.
R.0086	Submit description of any Provider financial incentive programs including, but not limited to, Physician incentive plans as defined in 42 CFR section 422.208.
R.0087	Submit description of efforts to promote value-based models and investments in Primary Care using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) Framework as outlined in the Alternative Payment Model (APM) Framework White Paper, https://hcp-lan.org/workproducts/apm-whitepaper.pdf.
R.0088	Submit policies and procedures for processing and payment of claims.
R.0089	Submit policies regarding the prohibition of a claim or demand for services provided under the Medi-Cal managed care contract to any Member.
R.0090	Submit any Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Network Provider Agreements to DHCS for approval.
R.0091	Submit policies and procedures for the reimbursement of non-contracting Certified Nurse Midwives (CNMs) and Nurse Practitioners (NPs).
R.0092	Submit policies and procedures for the reimbursement of Skilled Nursing Facilities and Nursing Facilities (SNF/NF).
R.0093	Submit policies and procedures for the reimbursement to LHDs and non-contracting family planning Providers for the provision of family planning services, STD episode, and HIV testing and counseling.
R.0094	Submit policies and procedures for the reimbursement of immunization services to LHD.

Identifier	Operational Readiness Requirement
R.0095	Submit policies and procedures regarding payment to non-contracting Emergency Services Providers. Include reimbursement schedules for all non-contracting Emergency Service Providers, including any schedule of per diem rates and/or Fee-for-Service (FFS) Rates for each of the following Provider types: 1) PCPs; 2) Medical Groups and Independent Practice Associations; 3) Specialists; and 4) Hospitals.
R.0096	Submit policies and procedures for reporting Provider-Preventable Conditions.
R.0247	Submit policies and procedures for pre-payment and post-payment claims review.

EXHIBIT A, ATTACHMENT III – 4.1 MARKETING

Identifier	Operational Readiness Requirement
R.0097	Submit policies and procedures for training and certification of Marketing Representatives.
R.0098	Submit a description of training program, including the Marketing Representative's training/certification manual.
R.0099	Submit Contractor's Marketing plan.
R.0100	Submit copy of boilerplate request form used to obtain DHCS approval of participation in a Marketing event.

EXHIBIT A, ATTACHMENT III – 4.2 ENROLLMENTS AND DISENROLLMENTS

Identifier	Operational Readiness Requirement
R.0101	Submit policies and procedures for how Contractor will update and maintain accurate information on its contracting Providers.
R.0102	Submit policies and procedures for how Contractor will access and utilize Enrollment data from DHCS.
R.0103	Submit policies and procedures relating to Member disenrollment.

EXHIBIT A, ATTACHMENT III – 4.3 POPULATION HEALTH MANAGEMENT AND COORDINATION OF CARE

Identifier	Operational Readiness Requirement
R.0108	Submit evidence illustrating Contractor's MIS has the capacity to meet DHCS data integration and exchange requirements as outlined in Exhibit A, Attachment III, Subsection 4.3.3 (*Data Integration and Exchange*).

Identifier	Operational Readiness Requirement
R.0110	Submit policies and procedures for complying with the Risk Stratification/Segmentation (RSS) requirements in Exhibit A, Attachment III, Subsection 4.3.5 (*Population Risk Stratification and Segmentation, and Risk Tiering*).
R.0111	Submit Contractor's process(es) describing how Contractor identifies Significant Changes in Members' health status or level of care and how Contractor monitors to ensure appropriate re-stratification.
R.0112	Submit a list of the data used by Contractor's RSS approach that includes the required sources in Exhibit A, Attachment III, Subsection 4.3.5.A.5 (*Population Risk Stratification and Segmentation, and Risk Tiering*) at a minimum. For each type of data listed, Contractor must include a description of the data and its origin, and how the data will be incorporated into the RSS approach.
R.0113	Submit a description of Contractor's population RSS and Risk Tiering approach, as well as the processes for how RSS and Risk Tiers are used to connect Members to appropriate services.
R.0114	Submit the method of bias analysis used to analyze Contractor's RSS and Risk Tiering approach, and the analysis of whether any biases were identified and if so, how they were corrected.
R.0115	Submit policies and procedures for conducting an initial screening or assessment of each Member's needs within 90 days of Enrollment, for sharing that information with DHCS, other Contractors, or Providers on behalf of Members, as appropriate, and for monitoring the completion of the assessments.
R.0116	Submit a description of Contractor's Complex Care Management (CCM) program outlining the types of Members, populations and/or program criteria established, the CCM program's approach for both long-term chronic conditions and episodic, temporary interventions, and processes for fulfilling all the other CCM program requirements outlined in Exhibit A, Attachment III, Subsection 4.3.7.A.2 (*Care Management Programs*).
R.0117	Submit policies and procedures for handling care management, and the non-duplication of services when multiple Subcontractors, Downstream Subcontractors, and/or Providers are involved in a Member's care.
R.0118	Submit policies and procedures for assigning Care Managers to Members, and monitoring to ensure all Care Managers' responsibilities are fulfilled.
R.0119	Submit policies and procedures for documenting and maintaining Care Management Plans (CMPs).

Identifier	Operational Readiness Requirement
R.0120	Submit policies and procedures that meet the Basic PHM requirements outlined in Exhibit A, Attachment III, Subsection 4.3.8.A (*Basic Population Health Management*). Contractor's policies and procedures should address core Basic PHM, Care Coordination, care navigation and referral needs of all Members. Contractor's policies and procedures must also address requirements regarding wellness and prevention programs and chronic disease management programs.
R.0121	Submit evidence that Contractor is providing the Provider resources as required by Exhibit A, Attachment III, Subsection 4.3.8.B (*Basic Population Health Management*).
R.0122	Submit policies and procedures for identifying, referring, and providing EPSDT case management services for Members less than 21 years of age.
R.0123	Submit policies and procedures for identifying and providing care management services for Children and Youth with Special Health Care Needs (CYSHCN).
R.0124	Submit policies and procedures for identifying, referring, and providing care management services for Members at risk of developmental delay and eligible to receive services from the local Early Start Program.
R.0125	Submit policies and procedures for the provision of comprehensive wellness and prevention programs to all Members.
R.0126	Submit policies and procedures for providing Transitional Care Services as outlined in Exhibit A, Attachment III, Subsection 4.3.11.A (*Targeted Case Management Services*).
R.0127	Submit Contractor's standardized discharge risk assessment that identifies Members' risk for re-hospitalization, re-institutionalization, and substance use recidivism.
R.0128	Submit Contractor's strategy for developing policies and procedures for Discharge Planning and Transitional Care Services with each Network and out-of-Network Provider hospital within its Service Area(s).
R.0129	Submit policies and procedures for ensuring Discharge Planning documents are completed, and that the documents fulfill the requirements outlined in Exhibit A, Attachment III, Subsection 4.3.11.B (*Targeted Case Management Services*), and are provided to Members, parents, legal guardians, or Authorized Representatives (AR) when being discharged from a hospital, institution, or facility.
R.0131	Submit policies and procedures for coordinating care for Members who may need or are receiving services and/or programs from out-of-Network Providers.

Identifier	Operational Readiness Requirement
R.0132	Submit policies and procedures for identifying and referring the target populations for Targeted Case Management (TCM) programs within Contractor's Service Area(s) and for reaching out to Local Government Agencies (LGAs) to coordinate care, as appropriate, upon notification from DHCS that Members are receiving TCM services. Policies and procedures must include processes for ensuring non-duplicative services.
R.0133	Submit policies and procedures for identifying, referring, and coordinating care for Members in need of Non-specialty Mental Health Services (NSMHS), Specialty Mental Health Services (SMHS) and/or SUD treatment services with Contractor's Network, the County Mental Health Plan (MHP), Drug Medi-Cal Organized Delivery System (DMC-ODS) or Drug Medi-Cal, or other community resources. Contractor is required to use the State-approved screening and transition tools.
R.0134	Submit policies and procedures for identifying, referring, and coordinating care for Members requiring alcohol or SUD treatment services from both within and, if necessary, outside Contractor's Service Area(s) in partnership with the LGAs responsible for such services.
R.0135	Submit policies and procedures for identifying, referring, and coordinating care for Members with the local California Children's Services (CCS) Program.
R.0136	Submit policies and procedures for the identifying, referring, and coordinating care for Members with Developmental Disabilities (DD) in need of non-medical services from the local Regional Center (RC) that includes the duties of the RC liaison.
R.0137	Submit policies and procedures for ensuring Care Coordination of Local Education Agency (LEA) services, including PCP involvement in the development of the Member's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP).
R.0138	Submit policies and procedures for identifying, referring, and ensuring Care Coordination and non-duplication of services for Members who are eligible for or who are already receiving contracted school-based services, such as EPSDT and Behavioral Health Services, from either LEAs, FQHCs or community-based organizations.
R.0139	Submit policies and procedures for providing required dental services and dental-related services that includes the duties of Contractor's dental liaison.
R.0140	Submit policies and procedures for ensuring case management and Care Coordination of Members with the LHD Tuberculosis (TB) Control Officer. Policies and procedures must include assessing and referring Members with active TB and at risk of non-compliance with TB drug therapy to the LHD.

Identifier	Operational Readiness Requirement
R.0141	Submit policies and procedures for identifying and referring eligible Members for Women, Infants and Children Supplemental Nutrition Program (WIC) services.
R.0142	Submit policies and procedures for identifying and referring eligible Members to Home and Community-Based Services (HCBS) programs. Policies and procedures must include processes for ensuring non-duplicative services.
R.0143	Submit policies and procedures for identifying and referring eligible Members to the county In-Home Supportive Services (IHSS) program, the duties of Contractor's IHSS liaison. and ensure compliance with the requirements outlined in Exhibit A, Attachment III, Subsection 4.3.21 (*In-Home Supportive Services*).
R.0144	Submit policies and procedures that described the duties and responsibilities of Contractor's Indian Health Care Provider (IHCP) tribal liaison in working with IHCPs within Contractor's Service Area(s).
R.0248	Submit policies and procedures that describe the duties and responsibilities of Contractor's managed care liaisons, including training and notification requirements for each of the following required liaisons: 1) Long-Term Services and Supports (LTSS) Liaison; 2) Transportation Liaison; 3) CCS Liaison; and 4) County Child Welfare Liaison.

EXHIBIT A, ATTACHMENT III – 4.4 ENHANCED CARE MANAGEMENT

Identifier	Operational Readiness Requirement
R.0145	Submit an Enhanced Care Management (ECM) Model of Care (MOC) using the DHCS approved template. If Contractor has a previously approved MOC for implementation of ECM effective January 1, 2022, or July 1, 2022, Contractor may submit an attestation stating that there are no changes to the previously approved MOC. If Contractor has changes to a previously approved MOC, Contractor must submit an updated MOC with all changes in track-edits for DHCS review and approval. Contractor must submit to DHCS any Significant Changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, pursuant to Exhibit A, Attachment III, Subsection 4.4.5.D (*Enhanced Care Management Model of Care*) and in accordance with DHCS policies and guidance, including All Plan Letters (APLs). Significant Changes may include, but are not limited to, changes to Contractor's approach to administer or deliver ECM services, approved policies and procedures, and Subcontractor Agreements and Downstream Subcontractor Agreements boilerplates.

EXHIBIT A, ATTACHMENT III – 4.5 COMMUNITY SUPPORTS

Identifier	Operational Readiness Requirement
R.0146	Submit a Community Supports MOC using the DHCS approved template. If Contractor has a previously approved MOC for implementation of Community Supports effective January 1, 2022, or July 1, 2022, Contractor may submit an attestation stating that there are no changes to the previously approved MOC. If Contractor has changes to a previously approved MOC, Contractor must submit an updated MOC with all changes in track-edits for DHCS review and approval. Contractor must submit to DHCS any changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, pursuant to Exhibit A, Attachment III, Subsection 4.5.5.D (*Community Supports Model of Care*) and in accordance with DHCS policies and guidance, and APLs. Substantial changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services; approved policies and procedures; and Network Provider Agreement, Subcontractor Agreements, or Downstream Subcontractor Agreements boilerplates, as appropriate.

EXHIBIT A, ATTACHMENT III – 4.6 MEMBER GRIEVANCE AND APPEAL SYSTEM

Identifier	Operational Readiness Requirement
R.0147	Submit policies and procedures relating to Contractor's Member Grievance and Appeal system including compiling, aggregating, and reviewing Grievance and Appeal data.
R.0148	Submit policies and procedures for Contractor's oversight of the Member Grievance and Appeal system for the receipt, processing and distribution of Grievance and Appeals, including the expedited review of Appeals. Include a flow chart to demonstrate the process.
R.0149	Submit policies and procedures relating to Contractor's Grievances and the expedited review of Grievances as required by 42 CFR sections 438.402, 438.406, and 438.408, 28 CCR sections 1300.68 and 1300.68.01, and 22 CCR section 53858.
R.0150	Submit policies and procedures relating to the resolution of Discrimination Grievances.
R.0151	Submit policies and procedures relating to Contractor's Appeals process. Include Contractor's responsibilities in State Hearings, Independent Medical Review, and expedited Appeals.
R.0152	Submit format for monthly Grievance and Appeal report.

EXHIBIT A, ATTACHMENT III – 5.1 MEMBER SERVICES

Identifier	Operational Readiness Requirement
R.0153	Submit policies and procedures that address Member's rights and responsibilities. Include method for communicating them to both Members and Providers.
R.0154	Submit policies and procedures for training Contractor's Member Services staff on Member rights, responsibilities, and services available under this Contract.
R.0155	Submit policies and procedures for training Contractor's Network Providers, Subcontractors, and Downstream Subcontractors on Member rights, Covered Services, and other responsibilities.
R.0156	Submit policies and procedures for handling Member Grievances not related to an Adverse Benefit Determination (ABD).
R.0157	Submit policies and procedures for providing communication access to Members in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language interpreters, captioning, written communication, electronic format, plain language or written translations and oral interpreters, including Limited English Proficiency (LEP) Members, or non-English speaking.
R.0158	Submit policies and procedures regarding compliance with the Americans with Disabilities Act of 1990 (42 United States Code (USC) section 12101 et seq.), Section 504 of the Rehabilitation Act of 1973 (29 USC section 794), Section 1557 of the Patient Protection and Affordable Care Act (42 USC section 18116), SB 223 (Atkins, Chapter 771, Statutes of 2017), and SB 1423 (Hernandez, Chapter 568, Statutes of 2018), and Government Code(GC) section 11135, as required in APL 21-011.
R.0159	Submit the following consistent with the requirements of Exhibit E, Section 1.1.23 (*Confidentiality of Information*). Submit policies addressing Member's rights to confidentiality of medical information. Include procedures for release of medical information and the right to amend or correct Medical Records pursuant to 45 CFR sections 164.524 and 164.526.
R.0160	Submit policies and procedures for addressing Advance Directives.
R.0161	Submit policies and procedures for the training of Member services staff.
R.0162	Submit policies and procedures regarding the development content and distribution of Member information. Address appropriate reading level and translation of materials.
R.0163	Submit final approved Member Identification Card and Member Handbook.
R.0164	For non-COHS Contractors, submit policies and procedures explaining the Member's right to an Independent Medical Review (IMR) including when an expedited IMR is available to the Member.

Identifier	Operational Readiness Requirement
R.0165	Submit policies and procedures explaining the Member's right to a State Hearing after receiving a Notice of Appeal Resolution or in cases of Deemed Exhaustion. These policies and procedures must also include the information on the Member's right to an expedited State Hearing if his/her health condition is in jeopardy.
R.0166	Submit policies and procedures and live notice Contractor will send to Members advising them of how to obtain Member informing materials including the Member Handbook, and Provider Directory.
R.0167	Submit policies and procedures on the Member's right to disenroll at any time to enroll in another Medi-Cal Managed Care Plan pursuant to 22 CCR section 53891(c).
R.0168	Submit policies and procedures for notifying Members of changes in availability or location of Covered Services.
R.0169	Submit policies and procedures for Member selection of a PCP or non-physician medical practitioner. Include the mechanism used for allowing SPD Members to request a Specialist to serve as their PCP.
R.0170	Submit policies and procedures for Member Assignment to a PCP. Include the use of FFS utilization data and other data in linking a SPD to a PCP, or Specialist acting as the SPD's PCP.
R.0171	Submit policies and procedures for notifying the PCP that a Member has selected or has been assigned to within ten calendar days from the selection or assignment.
R.0172	Submit policies and procedures demonstrating how, upon entry into Contractor's Network, the relationship between Traditional and Safety-Net Providers and the Member is not disrupted, to the maximum extent possible.
R.0173	Submit policies and procedures for notifying Members of an ABD for denial, deferral, or modification of requests for Prior Authorization, including explanation of Deemed Exhaustion to the Member.
R.0249	Submit policies and procedures to demonstrate how, for dates of service on or after January 1, 2016, Contractor will make the data it maintains available within one Working Day of receipt data or information, or one Working Day after a claim is adjudicated or Encounter Data is received.
R.0250	Submit policies and procedures to demonstrate how Contractor will update its Provider Directory API at least weekly after receiving updated Provider information or being notified of any information that affects the content or accuracy of the Provider Directory.

Identifier	Operational Readiness Requirement
R.0251	Submit a hard copy of the patient access API and Provider Directory API documentation and the publicly accessible link or web URL where each API is located. The documentation must be accessible without any preconditions to access, and contents must include at a minimum the following information: 1) API syntax, function names, required and optional parameters supported and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns; 2) The software components and configurations an application must use to successfully interact with the API and process its response(s); and 3) All applicable technical requirements and attributes necessary for an application's registration with any authorized server(s) deployed in conjunction with the API.
R.0252	Submit a hard copy and a link to Contractor's publicly accessible Member educational resources that will achieve the following: 1) Demonstrate the steps Member may consider taking to help protect the privacy and security of their health information and the importance of understanding the security and privacy practices of any application to which they entrust their health information; and 2) Provide an overview of which types of organizations or individuals are and are not likely to be HIPAA covered entities, the oversight responsibilities of the Office for Civil Rights (OCR) and the Federal Trade Commission (FTC), and how to submit a complaint to OCR and FTC.

EXHIBIT A, ATTACHMENT III – 5.2 NETWORK AND ACCESS TO CARE

Identifier	Operational Readiness Requirement
R.0174	Submit policies and procedures on how Contractor will assist Members in selecting PCPs who are accepting new patients and how it will afford access to Primary Care and specialty care.
R.0175	Submit complete 274 Provider File demonstrating the ability to serve 60 percent of Potential Members, including SPD Members, in each of the counties that Contractor serves pursuant to this Contract.
R.0176	Submit policies and procedures for how Contractor will meet federal requirements for access and reimbursement Network and/or out-of-Network FQHC, RHC, Freestanding Birthing Center (FBC) services, CNMs, and Licensed Midwives (LMs).
R.0177	Submit policies and procedures that establish traditional and Safety-Net Provider participation standards.

Identifier	Operational Readiness Requirement
R.0178	Submit policies and procedures describing how Contractor will monitor Provider to Member ratios to ensure they are within specified standards.
R.0179	Submit policies and procedures regarding Physician supervision of non-physician medical practitioners.
R.0180	Submit policies and procedures to monitor and ensure how Contractor, Network Providers, Subcontractors and Downstream Subcontractors comply with timely access requirements for each of the following: 1) Standards for timely appointments; 2) Appropriate clinical timeframes; 3) Shortening or expanding timeframes; 4) Follow up appointments; 5) Triaging Member calls; 6) Telephone interpreters; and 7) Contractor's customer service line.
R.0181	Submit policies and procedures for how Contractor will ensure Network Provider hours of operation are no less than the hours of operation offered to other commercial or FFS recipients.
R.0182	Submit a policy regarding the availability of Contractor's Medi-Cal director or licensed Physician 24-hours-a-day, 7-days-a-week, and procedures for communicating with emergency room personnel.
R.0183	Submit all documents outlined for the Network Certification demonstrating that the proposed Network meets the appropriate Network adequacy standards set forth in this Contract and Welfare and Institutions Code (W&I) section 14197. See APL 23-001 for document specification and submission guidelines. Network certification must be submitted in accordance with the requirements placed upon DHCS pursuant to 42 CFR section 438.66(e).
R.0184	Submit policies and procedures for providing Emergency Services including 24-hr. /day access without Prior Authorization, follow-up and coordination of emergency care services.
R.0185	Submit policies and procedures for authorizing and arranging for out-of-Network access, including arranging transportation services for Members to access the out-of-Network Providers.

Identifier	Operational Readiness Requirement
R.0186	Submit policies and procedures for the provision of and access to each of the following: 1) Family planning services; 2) STD services; 3) HIV testing and counseling services; 4) COVID therapeutics (see APL 22-009); 5) Pregnancy termination; 6) Minor Consent Services; 7) Immunizations; 8) IHCP services; 9) CNM and NP services; 10) NSMHS for minors; and 11) Medication for Addiction Treatment (MAT).
R.0187	Submit policies and procedures for the timely referral and coordination of Covered Services to which Contractor, Subcontractor, or Downstream Subcontractor has moral objections to perform or otherwise support.
R.0188	Submit policies and procedures for the provision of 24 hour interpreter services at key points of contact.
R.0189	Submit policies and procedures regarding Contractor, Subcontractor, and Downstream Subcontractor compliance with State and federal language and communication assistance requirements.
R.0190	Submit policies and procedures regarding Contractor, Subcontractor, and Downstream Subcontractor compliance with civil rights laws requiring access for Members with disabilities.
R.0191	Submit a written description of the C&L services program and policies and procedures for monitoring and evaluation of the C&L services program.
R.0192	Submit an analysis demonstrating the ability of Contractor's Network to meet the ethnic, cultural, and linguistic needs of Contractor's Members.
R.0193	Submit policies and procedures for providing cultural competency/humility, sensitivity or diversity training for staff, Network Providers, Subcontractors, and Downstream Subcontractors at key points of contact.
R.0194	Submit policies and procedures describing Contractor's Member and family engagement strategy and how Contractor will ensure Member and/or parent and caregiver input into appropriate policies and decision-making.

Identifier	Operational Readiness Requirement
R.0195	Submit policies and procedures describing how Contractor will ensure the following with regards to the Community Advisory Committee (CAC): 1) How Contractor will ensure a diverse membership on the CAC that is reflective of Contractor's Service Area and includes adolescents and/or parents/caregivers of Members less than 21 years of age; 2) How Contractor will support Member participation in the CAC; 3) How Contractor will ensure the CAC will be involved in appropriate policies and decision-making; 4) How Contractor will actively facilitate communication and connection between the CAC and Contractor leadership.
R.0196	Submit policies and procedures for providing continuity of care including the completion of Covered Services by Providers and out-of-Network Providers.
R.0197	Submit policies and procedures for performance of Facility Site Reviews (FSR) and Medical Record reviews (FSR Attachments A and B), and performance of Facility Site physical accessibility reviews (FSR Attachment C).
R.0198	Submit the aggregate results of pre-operational Site Reviews to DHCS at the request of DHCS. The aggregate results must include all data elements specified by DHCS.

EXHIBIT A, ATTACHMENT III – 5.3 SCOPE OF SERVICES

Identifier	Operational Readiness Requirement
R.0199	Submit policies and procedures, including standards, for the provision of each of the following services for Members less than 21 years of age: 1) Children's preventive services; 2) Immunizations; 3) Blood Lead screens; and 4) EPSDT services.
R.0200	Submit policies and procedures for the provision of adult preventive services, including immunizations.
R.0201	Submit policies and procedures for the provision of each of the following services to pregnant Members: 1) Prenatal and postpartum care; 2) Use of American College of Obstetricians and Gynecologists (ACOG) standards and guidelines; 3) Comprehensive risk assessment tool for all pregnant Members; and 4) Referral to Specialists.
R.0202	Submit a list of appropriate hospitals available within the Network that provide necessary high-risk pregnancy services.

Identifier	Operational Readiness Requirement
R.0203	Provide a detailed description of health education system including policies and procedures regarding delivery of services, administration, and oversight.
R.0204	Provide a list and schedule of all health education classes and/or programs.
R.0205	Submit policies and procedures for the provision of Emergency Medical Transportation (EMT), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).
R.0206	Submit policies and procedures that define and describe what mental health services are to be provided by a licensed mental health care Provider.
R.0208	Submit policies and procedures for the provision of Major Organ Transplants as Covered Services.
R.0209	Submit policies and procedures for the provision of Long-Term Care (LTC) as Covered Services.
R.0210	Submit policies and procedures for the provision of services at non-contracted LTC facilities.
R.0211	Submit policies and procedures for conducting a Drug Use Review (DUR).
R.0212	Submit policies and procedures for the UM of covered pharmaceutical services, demonstrating compliance with mental health parity requirements set forth in 42 CFR section 438.900 *et seq.*
R.0213	Submit policies and procedures for the coverage of clinical trials and routine patient care costs.

EXHIBIT A, ATTACHMENT III – 5.4 COMMUNITY BASED ADULT SERVICES

Identifier	Operational Readiness Requirement
R.0215	Submit policies and procedures for referring a Member to a Community Based Adult Services (CBAS) Provider.
R.0216	Submit policies and procedures on arranging for the provision of CBAS unbundled services.
R.0217	Submit all policies and procedures required by the California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions, Section V.A.23.
R.0218	Submit policies and procedures for the initial assessment and reassessment of Members for eligibility to receive CBAS, including circumstances where Contractor may forgo a face-to-face review if eligibility has already been determined through another process.
R.0219	Submit policies and procedures for an expedited assessment process.
R.0220	Submit final draft of the written notice to be sent to Members after a CBAS assessment determination that results in a change to the Member's CBAS benefit.

Identifier	Operational Readiness Requirement
R.0253	Submit all policies and procedures on providing CBAS Emergency Remote Services (ERS).
R.0254	Submit policies and procedures for community participation for Members receiving CBAS.
R.0255	Submit policies and procedures for notifying DHCS of payments made to a CBAS Provider involved in a credible allegation of Fraud.

EXHIBIT A, ATTACHMENT III – 5.5 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Identifier	Operational Readiness Requirement
R.0207	Submit policies and procedures for when a Member becomes eligible for SMHS and/or SUD treatment services during the course of receiving NSMHS, including how Contractor will use required State-approved transition of care tool for coordinating care between Contractor and MHPs.
R.0213	Submit policies and procedures for handling of psychiatric emergencies during non-business hours.
R.0214	Submit policies and procedures for verifying the credentials of licensed mental health Providers of NSMHS.
R.0222	Submit policies and procedures for entering into agreements with MHPs, Non-specialty Mental Health Services Providers, county DMC-ODS plans, counties administering California Medicaid State Plan benefits, and SUD treatment Providers in order to comply with access standards and Care Coordination requirements, including those concerning the concurrent provision of covered NSMHS and SMHS consistent with WI section 14184.402(f)(1).
R.0223	Submit policies and procedures for the provision of SUD services including drug and alcohol Screening, Brief Intervention and Referral to Treatment (SBIRT) services, including: 1) Provision of SBIRT by a Member's PCP to identify, reduce, and prevent problematic substance use; 2) Referral, without requiring Prior Authorization, for SBIRT services for Members whose PCPs do not offer SBIRT services; and 3) Referral of Members to SUD treatment without requiring Prior Authorization, when there is a need beyond SBIRT services.

EXHIBIT A, ATTACHMENT III – 5.6 MOUs WITH LOCAL GOVERNMENT AGENCIES, COUNTY PROGRAMS, AND THIRD PARTIES

Identifier	Operational Readiness Requirement
R.0224	Submit executed MOUs, or documentation substantiating Contractor's efforts to negotiate MOUs to coordinate programs and services for Members with LGAs, third-party entities and county programs in Contractor's Service Area, even if Contractor is coordinating care and not financially responsible, to ensure Care Coordination, data sharing, and non-duplicative services for Members, including, but not limited to: 1) LHDs in each County within Contractor's Services Area for the following programs and services: a) CCS; b) Maternal and Child Health (MCH); c) TB Direct Observed Therapy (DOT); and d) Community Health Workers (CHW). 2) WIC agencies in each county within Contractors' Service Area. 3) LGAs such as the County Behavioral Health Department and County Social Services Department, in each county within Contractors' Service Area to assist with coordinating the following programs and services: a) SMHS; b) Alcohol and SUD treatment services, including counties administering State plan Drug Medi-Cal benefits and counties participating in DMC-ODS; and c)IHSS. 4) LGAs to coordinate programs and services for Members in each county within Contractors Service Area at a minimum: a) Social Services; and b) Child welfare departments. 5) RCs for persons with DDs.
R.0225	Submit executed MOUs, or documentation substantiating Contractor's efforts to negotiate MOUs to coordinate programs and services for Members with LGAs, third-party entities, and county programs in Contractor's Service Area, even if Contractor is coordinating care and not financially responsible, to ensure Care Coordination, data sharing, and non-duplicative services for Members, including at a minimum: 1) LEAs for IEPs or IFSPs; 2) California Department of Corrections and Rehabilitation, County Jails, and youth correctional facilities, as applicable 3) Third-party entities in each county within Contractor's Service Area, at a minimum: a) HCBS program agencies; b) Continuums of Care; c) First 5 county commissions;

Back to Agenda Back to Item

Identifier	Operational Readiness Requirement
R.0226	Submit policies and procedures for exchanging Member Information with MHPs and DMC-ODS or county Drug Medi-Cal Programs in compliance with State and federal privacy laws and regulations.
R.0227	Submit policies and procedures for maintaining collaboration among the parties to the MOU and monitoring and assessing the effectiveness of MOUs. Policies and procedures should include the requirement to review its MOUs annually for any needed modifications or renewal of responsibilities and obligations.
R.0228	Submit executed MOUs, or documentation substantiating Contractor's efforts to negotiate MOUs to coordinate programs and services for Members with LGAs in each county within Contractor's Service Area to assist with coordinating, at a minimum, Targeted Case Management (TCM).

EXHIBIT A, ATTACHMENT III – 6.0 EMERGENCY PREPAREDNESS AND RESPONSE

No deliverables listed for this Article. (To Become Effective on January 1, 2025)

EXHIBIT B, BUDGET DETAIL AND PAYMENT PROVISIONS

Identifier	Operational Readiness Requirement
R.0233	Submit documentation of the Coordination of Benefits Agreement (COBA) that Contractor has entered into with Medicare.

EXHIBIT C, GENERAL TERMS AND CONDITIONS

No deliverables listed for this Exhibit.

EXHIBIT D(f), SPECIAL TERMS AND CONDITIONS

No deliverables listed for this Exhibit.

EXHIBIT E, PROGRAM TERMS AND CONDITIONS

Identifier	Operational Readiness Requirement
R.0234	Submit policies and procedures explaining Contractor's data certification reporting method. Policies and procedures must include a template certification statement.
R.0235	Submit policies and procedures for the treatment of recoveries, including retention policies, process, timeframes, and documentation for reporting, for all recovery of overpayments.

Identifier	Operational Readiness Requirement
R.0236	Submit policies and procedures for how Contractor will comply with Cost Avoidance and Post-Payment Recovery for Members with Other Healthcare Coverage (OHC).
R.0237	Submit policies and procedures for how Contractor will comply with Third-Party Tort and Worker's Compensation Liability.
R.0238	Submit policies and procedures for how Contractor will comply with an investigation or a prosecution conducted by the Division of Medi-Cal Fraud and Elder Abuse (DMFEA) and/or the United States Department of Justice (US DOJ), including communicating requirements with Subcontractors and Downstream Subcontractors.

EXHIBIT F, CONTRACTOR'S RELEASE

No deliverables listed for this Exhibit.

EXHIBIT G, BUSINESS ASSOCIATE ADDENDUM

No deliverables listed for this Exhibit.

EXHIBIT H, CONFLICT OF INTEREST AVOIDANCE REQUIREMENTS

Identifier	Operational Readiness Requirement
R.0241	Submit updated report on any conflicts of interest and/or conflict avoidance plan, if requested by DHCS.

EXHIBIT I, CONTRACTOR'S PARENT GUARANTY REQUIREMENTS

Identifier	Operational Readiness Requirement
R.0242	Submit parent guaranty, if applicable.

EXHIBIT J, DELEGATION REPORTING AND COMPLIANCE PLAN

Identifier	Operational Readiness Requirement
R.0243	Submit delegation reporting and compliance plan (Template A, B, and C).

EXHIBIT K, EXCLUDED PROVISIONS AS TO CONTRACTORS NOT LICENSED PURSUANT TO THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

No deliverables listed for this Exhibit.

EXHIBIT L, REQUIREMENTS SPECIFIC TO CONTRACTOR

Any deliverables for Contractor-specific requirements will be stated in Exhibit L.

Exhibit A, ATTACHMENT III

1.0 Organization

The Department of Health Care Services (DHCS) seeks to ensure that only those managed care plans that have the organizational capacity, leadership, financial well-being, commitment to invest in our communities, and demonstrated ability to ensure program integrity and compliance with all applicable federal and State requirements and standards under this Contract, may be Contractors.

Article 1.0 outlines DHCS' requirements for plan organization and administration including key leadership roles, including the designation of a Chief Health Equity Officer having the authority to design and implement policies that ensure Health Equity is prioritized and addressed. Key personnel changes, including those relevant to Contractor, Subcontractors, and Downstream Subcontractors, must be reported to DHCS in a timely fashion. The financial health and well-being of Contractors are vital to ensuring access to Medi-Cal Covered Services, and, as such DHCS, requires reporting of financial data for review. In addition, DHCS will ensure minimum loss ratios are in place for Contractors, Subcontractors, and Downstream Subcontractors who take financial risk to provide services for Members. Additionally, requiring that a portion of profits invested back into the community, will help ensure that Contractors are seeking opportunities to work at a local level to further efforts to address Social Drivers of Health (SDOH) and drive improvements in quality, equity, and access to care.

Article 1.0 also outlines requirements for Contractors to ensure that they have a clear compliance plan to meet the requisite personnel, processes, and capacity as outlined in the Contract.

1.1 Plan Organization and Administration

1.1.1 Legal Capacity
1.1.2 Key Personnel Disclosure Form
1.1.3 Conflict of Interest – Current and Former State Employees
1.1.4 Contract Performance
1.1.5 Medical Decisions
1.1.6 Medical Director
1.1.7 Chief Health Equity Officer
1.1.8 Key Personnel Changes
1.1.9 Administrative Duties/Responsibilities
1.1.10 Member Representation
1.1.11 Diversity, Equity, and Inclusion Training

Back to Agenda Back to Item

Exhibit A, ATTACHMENT III

1.1 Plan Organization and Administration

1.1.1 Legal Capacity

Contractor must maintain the legal capacity to contract with Department of Health Care Services (DHCS) and, if required, maintain appropriate licensure as a health care service plan in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (KKA) as amended (Health and Safety Code (H&S) section 1340 *et seq.*). If Contractor is not currently licensed to operate in an awarded Service Area, within 30 Working Days of award of Contract, it must submit a material modification to its license to the Department of Managed Health Care (DMHC) requesting authorization to operate in the Service Area. Contractor must submit proof of its material modification submission to DHCS concurrently. Operations Period will not begin until the material modification is approved by DMHC. Within three Working Days of approval, Contractor must submit a copy of its approved and amended Knox-Keene license to DHCS.

1.1.2 Key Personnel Disclosure Form

A. Contractor must file an annual statement with DHCS disclosing any purchases or leases of services, equipment, supplies, or real property from an entity in which any of the following persons have a substantial financial interest:

1) Any person or corporation having five percent or more ownership or controlling interest in Contractor;

2) Any director, officer, partner, trustee, or employee of Contractor; and

3) Any member of the immediate family of any person designated in 1) or 2) above.

B. Contractor must comply with 42 Code of Federal Regulations (CFR) sections 455.104 (Disclosure by Medicaid providers and fiscal agents: Information on ownership and control), 455.105 (Disclosure by providers: Information related to business transactions), 455.106 (Disclosure by providers: Information on persons convicted of crimes), and 438.610 (Prohibited affiliations).

1.1.3 Conflict of Interest – Current and Former State Employees

A. This Contract will be governed by the conflict of interest provisions of 42 CFR sections 438.3(f)(2) and 438.58 and 22 California Code of Regulations (CCR) sections 53874 and 53600.

B. In the performance of this Contract, Contractor will not utilize any State officer, employee in State civil service, other appointed State official, or intermittent State employee, or contracting consultant for DHCS, unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular State employment.

1.1.4 Contract Performance

Contractor must maintain the necessary organization and level of staffing to implement and operate this Contract in accordance with 28 CCR section 1300.67.3 and 22 CCR sections 53800, 53851, and 53857. Contractor must ensure the following:

A. Contractor has an accountable Governing Board;

B. Compliance with this Contract is a high priority and that Contractor is committed to supplying any necessary resources to assure full performance of the Contract;

C. If Contractor is a subsidiary organization, its parent organization provides an attestation confirming that this Contract will be a high priority to the parent organization and committing to supply any necessary resources to assure full performance of the Contract;

D. Adequate staffing in medical and other health services, fiscal and administrative capacity sufficient to effectively conduct Contractor’s business; and

E. Written procedures are developed and maintained for conducting Contractor’s business, including the provision of health care services, in compliance with federal and State Medicaid law.

1.1.5 Medical Decisions

Contractor must ensure that medical decisions, including those by Subcontractors, Downstream Subcontractors, Network Providers, and other Providers, are not unduly influenced by fiscal and administrative management.

1.1.6 Medical Director

Contractor must appoint a physician as medical director pursuant to 22 CCR section 53857 whose responsibilities must include, but should not be limited to, the following:

A. Ensuring that medical and other health services decisions are:

1) Rendered by qualified medical personnel; and

2) Not influenced by fiscal or administrative management considerations.

B. Ensuring that the medical and other health care provided meets acceptable standards of care;

C. Ensuring that Contractor's medical personnel follow medical protocols and rules of conduct;

D. Developing and implementing medical policy consistent with applicable standards of care;

E. Resolving Grievances related to Quality of Care;

F. Participating directly in the implementation of Quality Improvement and Health Equity activities;

G. Participating directly in the design and implementation of the Population Health Management Strategy and initiatives, including Population Needs Assessment design, planning, and implementation to inform Strategy;

H. Participating actively in the execution of Grievance and Appeal procedures;

I. Ensuring that Contractor engages with local health departments; and

J. Posting medical director contact information in an easily accessible location on their provider portal website.

1.1.7 Chief Health Equity Officer

Contractor must maintain a full-time Chief Health Equity Officer who has the necessary qualifications or training at the time of hire or within one year of hire to

meet the requirements of the position. The Chief Health Equity Officer responsibilities must include, but should not be limited to, the following:

A. Provide leadership in the design and implementation of Contractor's strategies and programs to ensure Health Equity is prioritized and addressed;

B. Ensure all Contractor policy and procedures consider Health Inequities and are designed to promote Health Equity where possible, including but not limited to:

1) Marketing strategy;

2) Medical and other health services policies;

3) Member and provider outreach;

4) Community Advisory Committee;

5) Quality Improvement activities, including delivery system reforms;

6) Grievance and Appeals; and

7) Utilization Management.

C. Develop and implement policies and procedures aimed at improving Health Equity and reducing Health Disparities;

D. Engage and collaborate with Contractor staff, Subcontractors, Downstream Subcontractors, Network Providers, and entities including, but not limited to local community-based organizations, local health departments, Behavioral Health and social services, Child welfare systems and Members in Health Equity efforts and initiatives;

E. Implement strategies designed to identify and address root causes of Health Inequities, which includes but is not limited to systemic racism, Social Drivers of Health, and infrastructure barriers;

F. Develop targeted interventions designed to eliminate Health Inequities;

G. Develop quantifiable metrics that can track and evaluate the results of the targeted interventions designed to eliminate Health Inequities;

H. Ensure all Contractor, Subcontractor, Downstream Subcontractor, and Network Provider staff receive mandatory diversity, equity and inclusion training (sensitivity, diversity, communication skills, and cultural competency/humility training) as specified in Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*) annually. This includes, but is not limited to:

1) Reviewing training materials to ensure the materials are up to date with current standards of practice; and

2) Maintaining records of training completion.

1.1.8 Key Personnel Changes

Contractor must report to DHCS Contract Manager any changes in the status of the executive-level personnel including, but not limited to the chief executive officer, chief financial officer, chief operations officer, the chief medical director, the chief Health Equity officer, the compliance officer, and government relations persons within ten calendar days. Contractor must also report to DHCS Contract Manager any changes in the status of the executive-level personnel for Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors including, but not limited to the chief executive officer, chief financial officer, chief operations officer, the medical director, the chief Health Equity officer, the compliance officer, and government relations persons within 20 calendar days.

1.1.9 Administrative Duties/Responsibilities

Contractor must maintain the organizational and administrative capabilities to carry out Contractor's duties and responsibilities under the Contract. At a minimum, Contractors' responsibilities must include the following:

A. Comply with all requirements and deliverables as described in Exhibit A, Attachment II, Article 1.0 (*Operational Readiness Deliverables and Requirements*);

B. Maintain financial records and books of account on an accrual basis, in accordance with Generally Accepted Accounting Principles (GAAP), which fully disclose the disposition of all Medi-Cal program funds received, as specified in Exhibit A, Attachment III, Section 1.2 (*Financial Information*);

C. Maintain a Member and Enrollment reporting systems as specified in Exhibit A, Attachment III, Section 2.1 (*Management Information System*),

Section 4.6 (*Member Grievance and Appeal System*), and Section 5.1 (*Member Services*);

D. Maintain data reporting capabilities sufficient to provide necessary and timely reports to DHCS, as required by Exhibit A, Attachment III, Section 2.1 (*Management Information System*);

E. Maintain data and information exchange capabilities as needed to meet Contractor's obligation under the Contract and to support DHCS administration of the Medi-Cal program through data sharing with other trading partners. This includes, but is not limited to, Encounter Data, Medical Record information, Network Provider and Provider information, Member demographics, and case notes;

F. Maintain Quality Improvement activities and Population Health Management activities. Comply with all National Committee for Quality Assurance (NCQA) and accreditation requirements by calendar year 2026 as described in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program (QIHETP)*);

G. Maintain a Utilization Management (UM) program, as described in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*);

H. Maintain Network adequacy as described in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*);

I. Comply with requirements, as described in Exhibit A, Attachment III, Section 3.2 (*Provider Relations*);

J. Maintain claims processing capabilities as described in Exhibit A, Attachment III, Section 3.3 (*Provider Compensation Arrangements*);

K. Maintain adequate access and availability of Primary Care Providers (PCP) and Specialists for all Medically Necessary Covered Services for Members, as described in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*);

L. Form a Community Advisory Committee (CAC) and meet expectations, as described in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*), including CAC's active participation in addressing Quality of Care, Health Equity, Health Disparities, Population Health Management, Children services, and other ongoing Contractor functions;

M. Provide or arrange for all Medically Necessary Covered Services for Members, as described in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*), Exhibit A, Attachment III, Section 5.4 (*Community Based Adult Services*), and Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*);

N. Provide Care Coordination, including but not limited to all Medically Necessary services delivered both within and outside Contractor's Network, as described in Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*);

O. Negotiate in good faith and execute Network Provider Agreements, Subcontractor Agreements, or Memorandums of Understanding (MOUs), as appropriate, with third party entities, including county programs, and local health jurisdictions covered by this Contract, as described in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) and Exhibit A, Attachment III, Subsection 3.1.9 *(Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments)*;

P. Comply with the requirements described in Exhibit A, Attachment III, Section 5.1 (*Member Services*);

Q. Maintain Member Grievance procedures, as specified in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

R. Develop training and certification for Marketing activity, if Contractor conducts Marketing, as described in Exhibit A, Attachment III, Section 4.1 (*Marketing*);

S. Cooperate with the DHCS Enrollment program, as described in Exhibit A, Attachment III, Section 4.2 (*Enrollments and Disenrollments*); and

T. Comply with all requirements and deliverables, as described in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*).

1.1.10 Member Representation

Contractor must ensure that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD), persons with chronic conditions (such as asthma, diabetes, congestive heart failure), Limited English Proficient (LEP) Members, and Members from diverse cultural and ethnic backgrounds or their representatives are included and invited to participate in establishing public

policy within Contractor's advisory committee and CAC, as specified in Exhibit A, Attachment III, Subsection 5.2.11.E. (*Cultural and Linguistic Programs and Committees*), or other similar committees or groups.

1.1.11 Diversity, Equity, and Inclusion Training

Contractor must ensure that all staff who interact with, or may potentially interact with, Members and any other staff deemed appropriate by Contractor or DHCS, receive annual sensitivity, diversity, communication skills, and cultural competency/humility training as specified in Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*).

Exhibit A, ATTACHMENT III

1.2 Financial Information

1.2.1 Financial Viability and Standards Compliance
1.2.2 Contractor's Financial Reporting Obligations
1.2.3 Independent Financial Audit Reports
1.2.4 Cooperation with DHCS' Financial Audits
1.2.5 Medical Loss Ratio
1.2.6 Contractor's Obligations
1.2.7 Community Reinvestment Plan and Report

1.2 Financial Information

1.2.1 Financial Viability and Standards Compliance

Contractor must meet and maintain financial viability and standards compliance to DHCS' satisfaction for each of the following elements:

A. Tangible Net Equity (TNE).

Contractor at all times must be in compliance with the TNE requirements set forth in 28 California Code of Regulations (CCR) section 1300.76, even in circumstances where Contractor is not otherwise legally required to comply with this provision.

B. Administrative Costs.

Contractor's Administrative Costs must comply with the standards set forth in 22 CCR section 53864(b) and 28 CCR section 1300.78.

C. Standards of organization and financial soundness.

Contractor must maintain an organizational structure sufficient to conduct the operations required by this Contract and ensure that its financial resources are sufficient for sound business operations in accordance with 28 CCR sections 1300.67, 1300.67.3, 1300.75.1, 1300.75.4.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, and 1300.77.4.

D. Working Capital Ratio of one of the following:

1) Contractor must maintain a Working Capital Ratio of current assets to current liabilities of at least 1:1 in accordance with Health & Safety Code (H&S) section 1375.4(b)(1)(A)(iv); or

2) Contractor must demonstrate to DHCS that Contractor is meeting financial obligations on a timely basis and has been doing so for at least the preceding two years; or

3) Contractor must provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent Working Capital Ratio of 1:1, if the noncurrent assets are considered current.

E. In the event DHCS finds Contractor non-compliant with any of the elements or obligations set forth in this provision, DHCS may impose a

Back to Agenda Back to Item

Corrective Action plan or sanctions in accordance with Exhibit E (*Program Terms and Conditions*) and Welfare and Institutions Code (W&I) section 14197.7, as set forth in in All Plan Letter (APL) 23-012. See Exhibit E, Section 1.19 (*Sanctions*).

1.2.2 Contractor's Financial Reporting Obligations

A. Form and Standards for Financial Reporting

Contractor must provide financial information and reports, including but not limited to Financial Statements, to DHCS in the form and manner specified by DHCS. Unless otherwise specified by DHCS, Contractor must prepare all financial information requested by DHCS in accordance with Generally Accepted Accounting Principles (GAAP) and the 1989 Health Maintenance Organization (HMO) Financial Report of Affairs and Conditions format. Any Department of Managed Health Care (DMHC) required reports must be prepared in DMHC-required financial reporting format, and in accordance with 28 CCR section 1300.84. Information submitted by Contractor must be based on current operations. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 (KKA) rules found under 28 CCR sections 1300.51 *et seq*.

Unless otherwise specified by DHCS, all Financial Statements must include, at a minimum, the following reports/schedules unless explicitly excluded in this Attachment:

1) Jurat;

2) Report 1A and 1B: Balance Sheet;

3) Report 2: Statement of Contract Revenue, Expenses, and Net Worth;

4) Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 in lieu of Report 3: Statement of Changes in Financial Position for GAAP compliance;

5) Report 4: Enrollment and Utilization Table;

6) Schedule G: Unpaid Claims Analysis;

7) Appropriate footnote disclosures in accordance with GAAP; and

Back to Agenda Back to Item

8) Schedule H: Aging of All Claims.

In addition, Contractor must prepare and submit a stand-alone Medi-Cal line of business income statement and Enrollment table on each financial reporting period required. Contractor must prepare this income statement and Enrollment table in the DMHC required financial reporting format for each specific county or rating region of operation, as specified by DHCS and must include, at a minimum, the following reports/schedules:

1) Report 2: Statement of Contract Revenue and Expenses; and

2) Report 4: Enrollment and Utilization Table by County/Rating Region.

Medi-Cal line of business Financial Statements are to include expenses, Contract Revenues, and Enrollment only for Medi-Cal Members enrolled through direct contract with DHCS.

Contactor must submit the Medi-Cal line of business Financial Statements within the same timeframe as indicated for each required Financial Statement.

B. Monthly Reporting Obligations

Contractor must submit to DHCS, no later than 30 calendar days after the close of Contractor's fiscal month, an exact copy of any reports required be filed in accordance with 28 CCR section 1300.84.3.

C. Quarterly Reporting Obligations

Contractor must submit to DHCS, no later than 45 calendar days after the close of Contractor's fiscal quarter, an exact copy of any reports required to be filed in accordance with 28 CCR section 1300.84.2.

D. Annual Reporting Obligations

Contractor must prepare and submit to DHCS, no later than 120 calendar days after the close of Contractor's Fiscal Year, an exact copy of any reports required to be filed in accordance with 28 CCR section 1300.84.06. Contractor must also submit Medi-Cal line of business Financial Statements no later than 120 calendar days of after the close of the applicable Rating Period.

E. Annual Forecasts

Contractor must submit to DHCS annual forecasts of Contractor's next Fiscal Year no later than 60 calendar days prior to the beginning each Fiscal Year. Contractor's annual forecast must be prepared using DMHC required financial reporting forms and must include, at a minimum, the following reports/schedules:

1) Report 2: Statement of Contract Revenue and Expenses (Medi-Cal line-of-business);

2) Report 4: Enrollment and Utilization Table by County/Rating Region (Medi-Cal line-of-business);

3) TNE (All lines of business); and

4) A detailed explanation of all underlying assumptions used to develop the forecast.

F. Publication of Financial Reports

Financial Reports submitted in accordance with this Section 1.2 are public records and may be made public by DHCS.

1.2.3 Independent Financial Audit Reports

Contractor must ensure that an annual audit is performed by an independent Certified Public Accountant in accordance with 42 Code of Federal Regulations (CFR) section 438.3(m) and W&I section 14459. Except as indicated in Paragraph B of this provision, a copy of the resulting independent financial audit report must be submitted to DHCS no later than 120 calendar days after the close of Contractor's Fiscal Year.

When the delivery of care or other services is dependent upon Affiliates of Contractor, Contractor must submit combined, annual Financial Statements that reflect the financial position of Contractor's overall health care delivery system in accordance with 28 CCR section 1300.84(c). Such combined, annual Financial Statements must be presented in a form that clearly shows the financial position of Contractor separately from the combined totals set forth in the combined Financial Statements. Intra-entity or related party transactions and profits must be eliminated if consolidated Financial Statements are prepared and submitted by Contractor. Contractor also must submit to DHCS any financial audit conducted by DMHC pursuant to H&S section 1382 within 30 calendar days of Contractor's receipt thereof.

In the event that Contractor's retained independent Certified Public Accountant determines that preparation of combined, annual Financial Statements is inappropriate or impracticable under the circumstances, separate certified Financial Statements must be prepared for each entity involved in the delivery of health care services by Contractor, and such separate, annual Financial Statements must be submitted to DHCS, along with the following:

A. Contractor must provide the independent Certified Public Accountant's written statement of the reasons for not preparing combined Financial Statements;

B. Contractor must provide supplemental schedules that clearly reflect all intra-entity or related party transactions and eliminations necessary to enable DHCS to analyze the overall financial position of Contractor's entire health care delivery system. If Contractor is a public entity or a political subdivision of the State and a county grand jury conducts Contractor's financial audits, Contractor must submit its Financial Statements within 180 calendar days after the close of Contractor's Fiscal Year in accordance with H&S section 1384;

C. Contractor must authorize its independent Certified Public Accountant to allow DHCS' designated representatives or agents, upon written request, to inspect any and all working papers related to the preparation of the audit report;

D. Contractor must submit to DHCS all financial reports relevant to Affiliates as specified in 28 CCR section 1300.84(c); and

E. Contractor must submit to DHCS copies of any financial reports submitted to any other public or private organization within ten calendar days of submission to such other public or private organization.

1.2.4 Cooperation with DHCS' Financial Audits

DHCS must conduct, or contract for the conduct of, periodic audits of the accuracy, truthfulness, and completeness of the financial data submitted by, or on behalf of, Contractor in accordance with 42 CFR section 438.602(e). Contractor must cooperate with these audits and provide all information and materials requested by DHCS, or its contracted auditor, for this purpose. Please see Exhibit A, Attachment III, Section 2.1 (*Management Information System*) for related requirements.

1.2.5 Medical Loss Ratio

Contractor must annually report a Medical Loss Ratio (MLR) as described in this provision and in accordance with 42 CFR section 438.8. Contractor must impose equivalent MLR reporting requirements on Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

A. Contractor must calculate and report a MLR as stated in 42 CFR sections 438.8 and 438.604(a)(3) in a form and manner specified by DHCS.

1) Contractor must ensure that revenues, expenditures, and other amounts are appropriately identified and classified including by distinguishing which amounts were actually paid for benefits~~,~~ or activities that improve health care quality, and which amounts were actually paid for administrative services, taxes, or other activities in accordance with the Centers for Medicare & Medicaid Services (CMS) Informational Bulletin published May 15, 2019, with the subject “Medical Loss Ratio Requirements Related to Third-Party Vendors.”

2) Contractor must, in compliance with 42 CFR section 438.230(c)(1) and California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions, in particular Paragraph 11 of the 1915(b) Waiver STCs, require all applicable Subcontractors and Downstream Subcontractors to comply with the MLR reporting responsibilities in this Section, including the requirement to distinguish which amounts are actually paid for benefits or activities that improve health care quality, and which amounts were actually paid for administrative services, taxes, or other activities in accordance with the CMS Informational Bulletin published May 15, 2019 with the subject “Medical Loss Ratio Requirements Related to Third-Party Vendors.” Payments to a Subcontractor or Downstream Subcontractor that are not the amount actually paid to a Provider or supplier for furnishing Covered Services must not be included in incurred claims.

B. The MLR experienced by Contractor in a MLR reporting year is the ratio of the numerator, as stated in Paragraph E of this Section, to the denominator, as stated in Paragraph F of this Section. A MLR may be increased by a credibility adjustment in accordance with Paragraph HH of this provision.

C. DHCS utilizes a materiality threshold for determining whether Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially

Back to Agenda Back to Item

Delegated Subcontractors are subject to the reporting and remittance requirements. The materiality threshold may be based on one or more of the following:

1) Annual Medi-Cal revenue;

2) The Medi-Cal lives for which risk is delegated;

3) The scope of Medi-Cal services for which risk is delegated; or

4) Other factors.

D. Subcontractors and Downstream Subcontractors that fall below the materiality threshold for an MLR reporting year, as specified by DHCS, are not subject to MLR reporting for that MLR reporting year. DHCS reserves the right to reestablish the threshold annually, may require reporting by certain Subcontractors and Downstream Subcontractors regardless of materiality, and will communicate details of the materiality threshold and subsequent updates and/or changes through APLs or other instruction.

E. The numerator of Contractor's, Subcontractors', and Downstream Subcontractors' MLR for a MLR reporting year is the sum of Contractor's, Subcontractors', and Downstream Subcontractors' incurred claims, expenditures for activities that improve health care quality, and Fraud prevention activities.

1) Contractor's, Subcontractors', and Downstream Subcontractors' Incurred Claims

a) Incurred claims must include the following:

i. Direct claims that Contractor, Subcontractors, and Downstream Subcontractors, as applicable, paid to Providers, including under capitated contracts with Network Providers, for Covered Services or supplies under this Contract, a Subcontractor Agreement, or a Downstream Subcontractor Agreement, as applicable, and meeting the requirements of 42 CFR section 438.3(e);

ii. Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims Incurred but Not Reported;

iii. Withholds from payments made to Network Providers;

iv. Claims that are recoverable for anticipated coordination of benefits;

v. Claims payments recoveries received due to subrogation;

vi. Incurred but Not Reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity;

vii. Changes in other claims-related reserves; and

viii. Reserves for contingent benefits and the medical claim portion of lawsuits.

b) Amounts that must be deducted from incurred claims include the following:

i. Identified unrecovered Overpayments and Overpayment recoveries received from Network Providers;

ii. Prescription Drug rebates received and accrued; and

iii. Amounts received as remittances from Subcontractors and Downstream Subcontractors, as applicable, in accordance with Paragraph P of this provision and Exhibit B of this Contract. Subcontractors and Downstream Subcontractors must deduct amounts received as remittances from their downstream entities. The contracts between all downstream entities in Contractor's delegation arrangement must include this reference.

c) Expenditures that must be included in incurred claims include the following:

i. The amount of incentive and bonus payments made, or expected to be made, to Network Providers **that are tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to Providers**; and

ii. The amount of claims payments recovered through Fraud reduction efforts, not to exceed the amount of Fraud reduction expenses. The amount of Fraud reduction expenses must not include activities specified in E.2.c of this provision.

iii. The amount of payments made to providers under Directed Payment Initiatives.

d) Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to solvency funds mandated by DHCS.

e) The following amounts must be excluded from incurred claims.

i. Non-claims costs, which include:

(1) the amounts paid to third-party vendors for secondary network savings;

(2) amounts paid to third-party vendors for network development, administrative fees, claims processing, and Utilization Management (UM);

(3) amounts paid for professional or administrative services, including amounts paid to a Provider, that do not represent compensation or reimbursement for California Medicaid State Plan services or services defined in 42 CFR section 438.3(e) and provided to Members; and

(4) amounts paid for fines and penalties assessed by regulatory authorities; and

ii. Amounts paid to DHCS as remittances in accordance with Paragraph P of this provision and Exhibit B of this Contract; and

iii. Amounts paid to upstream entities as remittance in accordance with Paragraph P of this Subsection. The contracts between all downstream entities in Contractor's delegation arrangement must include this reference; and

iv. Amounts paid to Network Providers under 42 CFR section 438.6(d).

f) Incurred claims paid by an entity that is later assumed by another entity must be reported by the assuming entity for the entire MLR reporting year and no incurred claims for that MLR reporting year may be reported by the ceding entity.

2) Activities that improve health care quality must be in one of the following categories:

a) Contractor's, Subcontractors', and Downstream Subcontractors', as applicable, activity that meets the requirements of 45 CFR section 158.150 **(a) and** (b) and is not excluded under 45 CFR section 158.150(c);

b) Contractor's**,** Subcontractors', and Downstream Subcontractors', as applicable, activity related to any External Quality Review-related activity as described in 42 CFR sections 438.358(b) and (c); or

c) Contractor's, Subcontractors', and Downstream Subcontractors', as applicable, expenditure that is related to Health Information Technology (HIT) and meaningful use, meets the requirements placed on issuers set forth in 45 CFR section 158.151, and is not considered incurred claims, as defined in this Subsection.

3) Contractor's, Subcontractors', and Downstream Subcontractors', as applicable, expenditures on activities related to Fraud prevention as described in 45 CFR part 158, and not including expenses for Fraud reduction efforts as stated in Paragraph E.1.c.ii of this Subsection.

Back to Agenda Back to Item

F. The denominator of Contractor's, Subcontractors', and Downstream Subcontractors' MLR for a MLR reporting year must equal the adjusted premium revenue for Contractor's, Subcontractors', and Downstream Subcontractors' Medi-Cal line of business. The adjusted premium revenue is Contractor's, Subcontractors', and Downstream Subcontractors' premium revenue minus Contractor's, Subcontractors', and Downstream Subcontractors' federal, State, and local taxes and licensing and regulatory fees, and is aggregated in accordance with this Subsection.

1) Premium revenue includes the following for the MLR reporting year:

a) Capitation Payments, developed in accordance with 42 CFR section 438.4, and excluding payments made per 42 CFR section 438.6(d);

b) One-time payments for Member life events as specified in this Contract, including, but not limited to, Supplemental Payments and Additional Payments as set forth in provisions 1.7 and 1.8 of Exhibit B, respectively;

c) Other payments to Contractor approved under 42 CFR section 438.6(b)(3);

d) All changes to unearned premium reserves; and

e) Net payments or receipts related to Risk Sharing Mechanisms developed in accordance with 42 CFR sections 438.5 or 438.6.

f) Payments to Contractor for expenditures under Directed Payment Initiatives.

~~f~~**g**) Notwithstanding (a)-(c), for Subcontractors and Downstream Subcontractors, premium revenue includes all payments received pursuant to a Subcontractor Agreement or Downstream Subcontractor Agreement, excluding payments received in accordance with 42 CFR section 438.6(d).

2) Taxes, licensing, and regulatory fees for the MLR reporting year must include:

a) Statutory assessments to defray the operating expenses of any State or federal department;

Back to Agenda Back to Item

b) Examination fees in lieu of premium taxes as specified by State law;

c) Federal taxes and assessments allocated to Contractor, Subcontractors, or Downstream Subcontractors, as applicable, excluding federal income taxes on investment income, capital gains, and federal employment taxes;

d) State and local taxes and assessments including:

i. Any industry-wide or subset assessments, other than surcharges on specific claims, paid to the State or a locality directly.

ii. Guaranty fund assessments.

iii. Assessments of State or local industrial boards or other boards for operating expenses, or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by the State.

iv. State or local income, excise, and business taxes, other than premium taxes and State employment and similar taxes and assessments.

v. State or local premium taxes, plus State or local taxes based on reserves, if in lieu of premium taxes.

e) Payments made by Contractor, Subcontractors, and Downstream Subcontractors, as applicable, that are otherwise exempt from federal income taxes, for community benefit expenditures as defined in 45 CFR section 158.162(c), limited to the higher of either:

i. 3 percent of earned premium; or

ii. The highest premium tax rate in the State, multiplied by Contractor's, Subcontractors', or Downstream Subcontractors', as applicable, earned premium in the State.

3) If Contractor, or any Subcontractor or Downstream Subcontractor, is later assumed by another entity that becomes the new Contractor, Subcontractor, or Downstream Subcontractor under this

Contract, a Subcontractor Agreement, or a Downstream Subcontractor Agreement, the new Contractor, Subcontractor, or Downstream Subcontractors must report the total amount of the denominator for the entire MLR reporting year, and no amount under this Paragraph for that year may be reported by the ceding Contractor, Subcontractor, or Downstream Subcontractor.

G. In the allocation of expense, Contractor, Subcontractors, and Downstream Subcontractors must include each expense under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis. Contractor, Subcontractors, and Downstream Subcontractors must use the following methods to allocate expenses:

1) Allocation to each category must be based on a Generally Accepted Accounting Principles (GAAP) method that is expected to yield the most accurate results;

2) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense; and

3) Expenses that relate solely to the operation of a reporting entity, such as staff costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

H. Contractor, Subcontractors, and Downstream Subcontractors may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible to account for a difference between the actual and target MLRs that may be due to random statistical variation. The credibility adjustment is added to the reported MLR calculation before calculating any remittance.

1) Contractor, Subcontractors, and Downstream Subcontractors may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

2) If Contractor’s, Subcontractors, or Downstream Subcontractor’s experience is Non-Credible, it is presumed to meet or exceed the MLR calculation standards in this Subsection.

3) Non-credible and partially-credible Contractors, Subcontractors, and Downstream Subcontractors that meet the materiality threshold must submit an MLR report regardless of credibility.

4) Contractor, Subcontractors, and Downstream Subcontractors must fulfill these requirements by using the base credibility factors that CMS publishes ~~annually~~ in accordance with 42 CFR section 438.8(h)(4).

5) Contractor must submit a MLR report regardless of credibility. DHCS may require MLR reporting by certain Subcontractors or Downstream Subcontractors regardless of credibility.

I. Contractor, Subcontractors, and Downstream Subcontractors must aggregate data by Member groups as defined in this Contract, or as otherwise directed by DHCS. This may require separate reporting and MLR calculations for specific populations.

J. Contractor must report its MLR to DHCS by county or rating region. Subcontractors and Downstream Subcontractors must report their MLR at the Subcontractor or Downstream Subcontractor arrangement level, by county or rating region, to their upstream entity.

K. MLR Reporting requirements.

1) Contractor, Subcontractors, and Downstream Subcontractors must submit a report to DHCS that includes at least the following information for each MLR reporting year:

a) Total incurred claims;

b) Expenditures on Quality Improvement activities;

c) Expenditures related to activities compliant with 42 CFR sections 438.608(a) – (5), (7), (8), and (b);

d) Non-claims costs;

e) Premium revenue;

f) Taxes, licensing, and regulatory fees;

Back to Agenda Back to Item

g) Methodology(ies) for allocation of expenditures**, which must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, federal and State taxes and licensing or regulatory fees, and other non-claims costs, as described in 45 CFR section 158.170(b)**;

h) Any credibility adjustment applied;

i) The calculated MLR;

j) Any remittance owed to DHCS, if applicable;

k) A comparison of the information reported with the audited financial report required under 42 CFR section 438.3(m);

l) A description of the method used to aggregate data; and

m) The number of Member months.

2) Contractor must submit this report in a timeframe and manner determined by DHCS, but no longer than 12 months after the end of the MLR reporting year.

3) Contractor must require any Subcontractor or other third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within 180 calendar days from the end of the MLR reporting year, or within 30 calendar days of being requested by Contractor, whichever is sooner, regardless of current contracting limitations, to calculate and validate the accuracy of MLR reporting.

4) Contractor must require Subcontractors impose reporting requirements equivalent to the information required in 42 CFR section 438.8(k) on Downstream Subcontractors who accept financial risk to perform delegated activities and reporting responsibilities specific for those services they do not directly provide to Members, in accordance with 42 CFR section 438.230(c)(1). Subcontractors must comply with all applicable Medi-Cal laws and regulations, including applicable sub-regulatory guidance and provisions of this Contract, in accordance with 42 CFR section 438.230(c)(2).

5) Contractor, Subcontractors, and Downstream Subcontractors must attest to the accuracy of the MLR calculation in accordance with requirements of this provision when submitting the MLR report.

6) Contractor must ensure Subcontractor submissions are in accordance with the information required in 42 CFR section 438.8(k). Contractor is expected to review and provide oversight of Subcontractor MLR submissions. Specific expectations include, but are not to be limited to:

   a) Review of each applicable Subcontractor's MLR and reported medical cost per Member per month to identify and investigate outliers;

   b) Review of reported expenses to ensure medical and non-medical expenses are appropriately accounted for in the MLR calculation;

   c) Verification that reported expenses align with service volume reported in encounters;

   d) Verification that reported revenues align with the upstream entities' reported payments;

   e) Review of the reasonableness of methodologies for allocation of expenditures across multiple lines of business;

   f) Review of the reasonableness of IBNR estimates.

Contractor will impose the aforementioned review and oversight expectations on Subcontractors and Downstream Subcontractors, as applicable, for their downstream entities. The contracts between all downstream entities in Contractor's delegation arrangement must include a reference to Exhibit A, Attachment III, Subsection 1.2.5.K.4 and 6 (*Medical Loss Ratio*).

L. Contractor may be excluded from the reporting requirements in this provision in the first MLR reporting year of its operation. Contractor then must comply with these requirements beginning with the next MLR reporting year in which it contracts with DHCS, even if the first MLR reporting year was not a full 12 months.

M. Consistent with 42 CFR section 438.8(l), Contractor may exempt newly contracted Subcontractors and Downstream Subcontractors from the MLR

Back to Agenda Back to Item

reporting requirements in the Subcontractor's or Downstream Subcontractor's first MLR reporting year of its operation. Contractor then must require Subcontractors and Downstream Subcontractors to comply with the MLR reporting year requirements in the next reporting year even if the first MLR reporting year did not cover a full 12 months of operation.

1) Contractors must report any excluded Subcontractors and Downstream Subcontractors to DHCS by the end of the third quarter of that MLR reporting year utilizing DHCS' reporting form.

2) DHCS retains the discretion to reverse any exemption based on information obtained during the initial review of MLR reporting and/or subsequent State or federal reviews or audits. Contractor must comply, and must require their Subcontractors and Downstream Subcontractors to comply, with any such reversal and submit or amend MLR reporting as needed.

N. In any instance where DHCS makes a retroactive change to the Capitation Payments for a MLR reporting year and the MLR report has already been submitted to DHCS, Contractor must re-calculate the MLR for all MLR reporting years affected by the change and submit a new report meeting the reporting requirements in this Subsection.

O. Contractor must impose the above retroactive reporting requirements on its Subcontractors and Downstream Subcontractors where DHCS makes a retroactive change to the Capitation Payments for a MLR reporting year and the MLR report has already been submitted to Contractor or upstream Subcontractor. In its sole discretion, DHCS reserves the right to limit MLR re-reporting for Subcontractors and Downstream Subcontractors to no more than one instance and may require re-reporting on an ad hoc basis. Subcontractors and Downstream Subcontractors must not re-report a MLR more than once for any MLR reporting year absent DHCS' review and express permission for any such MLR re-reporting. DHCS has the sole authority and discretion to grant or deny permission to any request for a Subcontractor or Downstream Subcontractor to re-report more than once for any MLR reporting year. The contracts between all downstream entities in Contractor's delegation arrangement must include this reference.

P. Contractor must, if applicable, provide a remittance for a MLR reporting year in accordance with W&I section 14197.2(c)(1) and Exhibit B of this Contract. Starting January 1, 2025, Contractor must impose equivalent

Back to Agenda Back to Item

remittance requirements on Subcontractors and Downstream Subcontractors.

Q. In accordance with the CalAIM 1915(b) Waiver STCs, DHCS will work with CMS to effectuate an audit of MLR reports no sooner than the 2028 calendar year. The MLR audit will include the time period covered by the CalAIM 1915(b) Waiver (January 1, 2022 through December 31, 2026).

1) To allow DHCS and CMS to complete an accurate audit of the MLR reports, Contractors, Subcontractors, and Downstream Subcontractors must maintain all records and documents relating to MLR reports for a minimum of 10 years as described in 42 CFR section 438.3(u).

2) Pursuant to 42 CFR section 438.3(h), DHCS and its contractor(s) may, at any time, request, inspect, and audit any of Contractor's, Subcontractors', and Downstream Subcontractors' records or documents. Record retention requirements are also referenced in Exhibit E of this Contract.

1.2.6 Contractor's Obligations

A. Contractor is required to provide any other financial reports, data, or information not listed above as requested by DHCS to evaluate or monitor Contractor's financial condition.

B. If Contractor's incurred claims reported in accordance with Exhibit A, Attachment III, Subsection 1.2.5, Paragraph C.1.a.iii above includes withholds from payments made to Network Providers, Contractor must provide to DHCS a report, in a form and manner specified by DHCS, detailing the basis for those withholds.

1.2.7 Community Reinvestment Plan and Report

A. Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must annually submit a Community Reinvestment Plan for DHCS' approval that details its anticipated community reinvestment activities, pursuant to Exhibit B, Section 1.17 (*Community Reinvestment*), in a form and manner specified by DHCS through APLs or similar guidance. The Community Reinvestment Plan must detail the expected Members of Contractor's community reinvestment, how they will benefit, and any additional information requested by DHCS. DHCS will make available the parameters for

Back to Agenda Back to Item

allowable community reinvestment activities through APLs or similar guidance.

B. If Contractor has a Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor, Contractor must require the Fully Delegated Subcontractor and Downstream Fully Delegated Subcontractor to annually submit a Community Reinvestment Plan for approval that details its anticipated community reinvestment activities, pursuant to Exhibit B, Section, 1.17 (*Community Reinvestment*), in a form and manner specified by DHCS through APLs or similar guidance. Contractor must submit the Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's Community Reinvestment Plan to DHCS.

C. Contractor must annually submit a Community Reinvestment Report, including information related to any Fully Delegated Subcontractor's or Downstream Fully Delegated Subcontractor's Community Reinvestment Plan, to DHCS in a form and manner specified by DHCS through APLs or similar guidance. The Community Reinvestment Report must detail Contractor's community reinvestment activities in accordance with the Community Reinvestment Plan, and the outcomes thereof. DHCS will make available the minimum information requirements for the report through APLs or similar guidance.

Back to Agenda Back to Item

Exhibit A, ATTACHMENT III

1.3 Program Integrity and Compliance Program

1.3.1 Compliance Program
1.3.2 Fraud Prevention Program
1.3.3 Provider Screening, Enrolling, and Credentialing/Recredentialing
1.3.4 Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers
1.3.5 Disclosures
1.3.6 Treatment of Overpayment Recoveries
1.3.7 Federal False Claims Act Compliance and Support

1.3 Program Integrity and Compliance Program

Contractor must establish administrative and management policies and procedures which are designed to prevent and detect Fraud, Waste, and Abuse. In furtherance of this goal, Contractor must establish a Compliance program, a Fraud, Waste, and Abuse prevention program, and other program integrity processes, as set forth in this Exhibit A, Attachment III, Section 1.3 (*Program Integrity and Compliance Program*). In establishing these policies, procedures, and programs, Contractor must meet the requirements of 42 Code of Federal Regulations (CFR) section 438.608.

While Contractor may contract with entities to support Contractor on compliance activities (such as training and auditing), Contractor may not delegate program integrity and compliance program functions to Subcontractors or Downstream Subcontractors.

Contractors must ensure that all Subcontractors and Downstream Subcontractors also have a robust program integrity and compliance program in place. This requirement may be fulfilled by Contractor maintaining all program integrity and compliance program functions on behalf of Subcontractor or Downstream Subcontractor.

1.3.1 Compliance Program

Contractor must have a compliance program that includes, at a minimum, the following elements:

A. A compliance plan which:

1) Outlines the key elements of the compliance program;

2) Includes reference to the standards of conduct or code of conduct;

3) Allows the compliance program to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance;

4) Details how it will implement and maintain elements of the compliance program;

5) Includes the compliance reporting structure and positions of key personnel involved in ensuring compliance, including the compliance officer;

6) References the delegation reporting and compliance plan

7) References policies and procedures operationalizing the compliance program;

8) Is reviewed and approved by the board of director's compliance and oversight committee routinely, but not less than annually; and

9) Is publicly posted on Contractor's website.

B. Standard of conduct or code of conduct must clearly articulate Contractor's commitment to comply with all applicable requirements and standards under this Contract, and all applicable federal and State requirements. It must describe the organizational expectations that all employees, officers, board of directors, Network Providers, Subcontractors, and Downstream Contractors act ethically and have a responsibility in ensuring compliance. Standard of conduct must be approved by Contractor's full board of directors annually.

C. Written policies and procedures which address the following:

1) Detail how elements of the compliance program are operationalized, including the titles of persons responsible for specific activities;

2) Describe how Contractor will oversee all Network Providers, Subcontractors, Downstream Subcontractors, and third-party entities compliance with all applicable terms and conditions of the Contract. See also, Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*); and

3) Outline Contractor's process to ensure policies and procedures are reviewed at least annually and how changes are disseminated to impacted operational areas. Contractor must update the policies and procedures to incorporate changes in applicable laws, regulations, and requirements.

D. A delegation reporting and compliance plan as described in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan*) and Exhibit J *(Delegation Reporting and Compliance Plan)*;

E. The designation of a compliance officer who is responsible for developing, implementing, and ensuring compliance with the requirements and standards under the Contract and who reports directly to the chief executive officer and the board of directors. Contractor's policies and procedures must include the criteria for selecting a compliance officer and a job description, including responsibilities and the authority of this position. The compliance officer must be a full-time employee and must be independent, which means they must not serve in both a compliance and operational role, for example, when the compliance officer is the chief operating officer, finance officer or general counsel.

F. The establishment of a regulatory compliance and oversight committee of the board of directors and at the senior management level charged with overseeing Contractor's compliance program and compliance with the requirements under this Contract. Contractor's policies and procedures must include the criteria for selecting members to the committee. The committee must review the compliance plan on an annual basis. The committee must meet at least quarterly to oversee the compliance program, including, reviewing areas of non-compliance and implementation and monitoring of corrective actions.

G. A system for training and educating the compliance officer, senior management, and employees on federal and State standards and requirements of this Contract. Trainings must address Contractor's standards of conduct, compliance plan, and compliance policies and procedures compliance training completion must be verified such as through a certification or attestation upon training completion and review of the standard of conduct, compliance program, and compliance policies and procedures. Contractor must ensure that training for the compliance officer, senior management, and employees on the compliance program is completed within 90 days of employment and annually thereafter.

H. A system for board members, officers, senior management, and employees to receive training on policies and procedures related to compliance for specific job functions including but not limited to:

1) Compliance officer, senior management, and employees training and education on the overall compliance program, Fraud, Waste, and Abuse, and code of conduct in accordance with Exhibit A, Attachment III, Section 1.3 (*Program Integrity and Compliance Plan*);

2) Network Providers completion of required initial and ongoing Network Provider training within the established timeframes in

accordance with Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training*), Members' rights as required under Exhibit A, Attachment III, Section 3.2 (*Provider Relations*), and Advanced Directives in accordance with 42 CFR sections 422.128 and 438.3(j) set forth in Exhibit A, Attachment III, Subsection 5.1.1 (*Members Rights and Responsibilities*);

3) Member Services staff completion of required training as set forth in Exhibit A, Attachment III, Subsection 5.1.2 (*Member Services Staff*) and include diversity, equity and inclusion training in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*); and

4) For staff carrying out obligations under MOUs, the training required under Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*)

I. Effective lines of communication between the compliance officer and employees. For example, Contractor must establish a consistent process for distributing and communicating new regulations, regulatory changes, or changes relevant to this Contract. Contractor will communicate this process to all Subcontractors, Downstream Subcontractors, and Network Providers, as applicable. Lines of communication must be accessible to all employees, and include a mechanism to enable anonymous and confidential good faith reporting of potential compliance issues by any employee, Member, Network Provider, Subcontractor, or other person or entity, as they are identified.

J. Enforcement of standards through well-publicized disciplinary guidelines. This includes, but is not limited to:

1) Establishment and implementation of disciplinary policies and procedures that reflect clear and specific disciplinary standards as well as Contractor's expectation for reporting of issues related to noncompliance or illegality; training expectations and disciplinary or enforcement standards when noncompliant activity is found.

2) To demonstrate that disciplinary guidelines are enforced, Contractor must maintain records of disciplinary actions for a period of ten years years at a minimum, including date of and description of violation, date of investigation, findings and date and description disciplinary action.

K. Contractor must develop and maintain effective systems for routine monitoring and auditing, and identification of compliance risks including but not limited to:

1) Dedicated staff for routine internal monitoring and auditing of compliance risks;

2) Methods and tools for assessing whether Contractor activities required under this Contract comply with State and federal law and this Contract. This includes having methods and tools to evaluate and trend an activity over time to assess noncompliance;

3) Routine and periodic reporting of internal monitoring and auditing activities and results to compliance and oversight committee of the board; and

4) Unannounced audits of Subcontractors and Downstream Subcontractors to assess the compliance with requirements set forth in this Contract as relevant to delegated functions.

L. Contractor must develop and maintain effective systems for prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Contract (42 CFR section 438.608(a)).

1) This includes policies and procedures for constructing and implementing effective Corrective Action plans, including root cause analysis and tailoring Corrective Action plans to address specific compliance concerns;

2) Corrective action plans must be reviewed and signed by the compliance officer and the executive officer responsible for the area subject to the Corrective Action plan;

To demonstrate effective systems to address compliance concerns and implement effective corrective action, Contractor must maintain and publicly post records of Corrective Action plans and the rectifying actions to close out the findings, including but not limited to, committee meeting minutes detailing discussion of corrective action plans and description of outcomes; and

3) Contractor must ensure contractual provisions are in place through Subcontractor Agreements and Downstream Subcontractor Agreements, as relevant, to enforce compliance with Corrective Action plans when they are not met, such as financial sanctions, payment withholds, or liquidated damages.

1.3.2 Fraud Prevention Program

Contractor must have a Fraud prevention program that at a minimum sets forth policies and procedures for the elements identified in this Exhibit A, Attachment III, Subsection 1.3.2 (*Fraud Prevention Program*).

A. Fraud Prevention Officer

Contractor must designate a Fraud prevention officer who is responsible for developing, implementing, and ensuring compliance with Contractor's Fraud prevention program and who reports directly to the chief executive officer and the board of directors. The Fraud prevention officer must attend and participate in DHCS' quarterly program integrity meetings, as scheduled. The same individual may serve as both the compliance officer and the Fraud prevention officer.

B. Notification of Changes in Member's Circumstances

Contractor must promptly notify DHCS when Contractor receives information about changes in a Member's circumstances that may affect the Member's eligibility including changes in the Member's residence, income, insurance status, and death (42 CFR section 438.608(a)(3)). This notification will be in a form and manner specified by DHCS through All Plan Letters (APLs), or other similar instructions.

C. Method to Verify Services Received

Contractor must have a regular method to verify, by sampling or other methods, confirming that services that have been represented to have been delivered by Network Providers were received by Members (42 CFR section 438.608(a)(5)). Contractor must provide proof of compliance with this requirement when requested by DHCS, in a form and manner specified by DHCS through APLs, or other similar instruction.

D. Contractor's Reporting Obligations

In accordance with 42 CFR section 438.608(a)(7), Contractor must refer, investigate, and report all Fraud, Waste, and Abuse activities that

Back to Agenda Back to Item

Contractor identifies to DHCS' Program Integrity Unit (PIU), in a manner prescribed by PIU, as follows:

1) Preliminary Fraud, Waste, and Abuse Reports

Contractor must file a preliminary report with DHCS' PIU detailing any suspected Fraud, Waste, or Abuse identified by or reported to Contractor, its Subcontractors, its Downstream Subcontractors, and/or its Network Providers within ten Working Days of Contractor's discovery or notice of such Fraud, Waste, or Abuse. Contractor must submit a preliminary report in accordance with requirements set forth in APLs or other similar instructions. Subsequent to the filing of the preliminary report, Contractor must promptly conduct a complete investigation of all reported or suspected Fraud, Waste, and Abuse activities.

2) Completed Investigation Report

Within ten Working Days of completing its Fraud, Waste, or Abuse investigation (including both Contractor-initiated and DHCS-initiated referrals), Contractor must submit a completed report to DHCS' PIU. This report must include Contractor's findings, actions taken, and include all documentation necessary to support any action taken by Contractor, and any additional documentation as requested by DHCS or other State and federal agencies.

3) Quarterly Fraud, Waste, Abuse Status Report

Contractor must submit a quarterly report to DHCS' PIU on all Fraud, Waste, and Abuse investigative activities ten Working Days after the close of every calendar quarter. The quarterly report must contain the status of all preliminary, active, and completed investigations and must include both Contractor-initiated and DHCS-initiated referrals. In addition to quarterly reports, Contractor must provide updates and available documentation as DHCS may request from time to time.

4) Manner of Report Submission

Contractor must electronically submit each Fraud, Waste, and Abuse report required under the Contract in a manner prescribed by DHCS' PIU. The required reports must include but not be limited to the preliminary Fraud report, the completed investigation report, and the quarterly status report, including all supporting documents,

Back to Agenda Back to Item

and any additional documents requested by DHCS, in a form and manner specified by DHCS through APLs, or other similar instructions.

5) Contractor's Obligation to Investigate State, federal, and other Medi-Cal managed care plans' Referrals of Fraud, Waste, and Abuse.

DHCS may, from time to time, share with Contractor relevant Fraud, Waste, and Abuse referrals received from State and federal agencies and other Medi-Cal managed care plans. Contractor may also receive Fraud, Waste, and Abuse referrals directly from other federal agencies, State agencies (other than DHCS), and Medi-Cal managed care plans.

Contractor must conduct a complete investigation of all Fraud, Waste, and Abuse referrals received from DHCS, other State and federal agencies, and other Medi-Cal managed care plans, relating to Contractor's Subcontractors, Downstream Subcontractors, and Network Providers. Contractor must submit a completed investigation report and a quarterly status report, as set forth above in this Exhibit A, Attachment III, Subsection 1.3.2.D (*Contractor's Reporting Obligations*), in connection with all DHCS, State and federal agency, and Medi-Cal managed care plan referrals of Fraud, Waste, and Abuse.

6) Confidentiality

Contractor acknowledges that information shared by DHCS, other State and federal agencies, and other Medi-Cal managed care plans in connection with any Fraud, Waste, or Abuse referral must be considered confidential, until formal criminal proceedings are made public. Contractor further acknowledges that it is receiving this Confidential Information as a DHCS business associate in order to facilitate Contractor's contractual obligations to maintain a Fraud, Waste, and Abuse prevention program. Contractor must receive and maintain this Confidential Information in its capacity as a Medi-Cal managed care plan and will use the Confidential Information only for conducting an investigation into any potential Fraud, Waste, or Abuse activities and in furtherance of any other program integrity activities.

In the event Contractor is required to share this Confidential Information with a Subcontractor, Downstream Subcontractor, or

Back to Agenda Back to Item

Network Provider, Contractor must ensure that Subcontractor, Downstream Subcontractor and Network Provider acknowledge that such information must be kept confidential by Subcontractor, Downstream Subcontractor, and Network Provider, and a similar provision of confidentiality must be included in all Subcontractor Agreements, Downstream Subcontractor Agreements, and Network Provider Agreements.

1.3.3 Provider Screening, Enrolling, and Credentialing/Recredentialing

A. Screening and Enrolling

All Network Providers must be screened and enrolled in accordance with this Contract, applicable State and federal law, including 42 CFR section 438.602(b), and APL 22-013.

1) If Contractor chooses not to utilize the State level Enrollment pathway, Contractor must notify DHCS and send to DHCS its policies and procedures for review and approval before conducting its own Enrollment process.

2) Contractor may allow Network Providers to participate in their Network for up to 120 calendar days if the Network Provider has a pending Enrollment application in review with DHCS or with Contractor in accordance with 42 CFR section 438.602(b)(2).

3) Contractor must terminate its contract with the provider no later than 15 calendar days of the provider receiving notification from DHCS that the provider has been denied Enrollment in the Medi-Cal program, or upon the expiration of the first 120-day period. Contractor cannot continue to contract with providers during the period in which the provider resubmits its Enrollment application to DHCS or Contractor and can only re-initiate a contract upon the provider's successful enrollment.

B. Credentialing/Recredentialing

Contractor has an on-going obligation to credential and recredential Providers and Network Providers in accordance with this Contract (Exhibit A, Attachment III, Subsection 2.2.13 (*Credentialing and Recredentialing*)), applicable State and federal law, including 42 CFR section 438.602(b), and APL 22-013.

1.3.4 Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers

Contractor has a continuing obligation to verify that Contractor's Network Providers are enrolled and remain enrolled in the Medi-Cal program. Contractor is responsible for knowledge of all ineligible Providers and individuals on these lists.

A. Tracking Suspended, Excluded, and Ineligible Providers

Contractor must review the following exclusionary databases and lists no less frequently than monthly and take appropriate action in accordance with APL 15-026 and APL 21-003.

1) List of Suspended and Ineligible Providers located at https://www.medi-cal.ca.gov;

2) List of excluded individuals and entities maintained by the U.S. Department of Health and Human Services (U.S. DHHS), Office of Inspector General located at https://oig.hhs.gov;

3) The System of Award Management (SAM);

4) The Social Security Administration Death Master File (SSADMF);

5) To the extent applicable, National Plan and Provider Enumeration System (NPPES); and

6) Restricted Provider Database

Contractor must notify DHCS' PIU within ten Working Days of removing a suspended, excluded, or ineligible Providers or individual from its Network and confirm that the ineligible Provider is no longer receiving payments, either directly or indirectly, in connection with the Medi-Cal program. A suspended, excluded, and ineligible Provider report must be sent to DHCS PIU in a manner prescribed by DHCS' PIU.

B. No Contracts with Excluded, Suspended, or Ineligible Providers

Contractor is prohibited from employing, paying, contracting, or maintaining a Medi-Cal contract with Providers that are excluded, suspended, or ineligible to participate, either directly or indirectly, in the

Medicare or Medi-Cal programs (42 CFR section 438.610(a)-(c) and APL 21-003).

C. Notification and Termination of Contracts

Contractor must promptly notify DHCS when Contractor receives information about a change in a Network Provider's, Subcontractor's, or Downstream Subcontractor's circumstances that may affect the Network Provider's, Subcontractor's, or Downstream Subcontractor's eligibility to participate in the Medi-Cal managed care program, including the termination of their Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement with Contractor in accordance with this Contract, State and federal law, including 42 CFR section 438.608(a)(4), and APL 21-003.

D. Actions to be taken where Credible Allegation of Fraud

If DHCS, Division of Medi-Cal Fraud and Elder Abuse (DMFEA), or United States Department of Justice (US DOJ), or any other authorized State or federal agency, determines there is a credible allegation of Fraud against Contractor's Subcontractor, Downstream Subcontractor, or Network Provider, Contractor must comply with this Contract, all applicable State and federal laws, APL 15-026, and APL 21-003. Contractor must have procedures in place to immediately suspend payments to Subcontractors, Downstream Subcontractors, and Network Providers for which a State or federal agency determines there is a credible allegation of Fraud (42 CFR section 438.608(a)(8)). In addition, Contractor may conduct additional monitoring, temporarily suspend, and/or terminate the Network Provider, Subcontractor, or Downstream Subcontractor.

1.3.5 Disclosures

In accordance with 42 CFR section 438.608(c), Contractor, its Subcontractors, and its Downstream Subcontractors must:

A. Provide written disclosure of any prohibited affiliation under 42 CFR section 438.610; and

B. Provide written disclosures of information on ownership and control as required under 42 CFR section 455.104.

C. Report and return any payment to DHCS within 60 calendar days of when it has identified any Capitation Payments or other payments it has received or paid in excess of the amounts specified in this Contract.

1.3.6 Treatment of Overpayment Recoveries

A. Retention, Reporting, and Payment of Recoveries

Contractor must comply with guidelines issued by DHCS pertaining to retention policies for the treatment of recoveries of all overpayments from Contractor to a Provider, including for the treatment of recoveries of overpayments due to Fraud, Waste, or Abuse. Contractor must also comply with the process, timeframes, and documentation required for reporting and paying to DHCS the recovery of overpayments, as set forth in APL 23-011. APL 23-011 requires Contractor to notify DHCS of any identified or recovered overpayments to a Provider due to potential fraud, waste or abuse. Contractor must notify its Managed Care Operations Division (MCOD) Contract Manager (CM) within 10 calendar days of the date that the overpayment, and the DHCS Audits and Investigations Unit regardless of the amount.

Contractor must split equally overpayment recoveries of $25 million or more with DHCS. Contractor must report an overpayment of $25 million or more to DHCS through their assigned MCOD CM within 60 calendar days of the date that the overpayment. In addition, Contractor must comply with this Contract, and all applicable State and federal law regarding overpayment recoveries, including 42 CFR sections 438.608(a)(2) and (d).

A Contractor can retain each overpayment recovery that is less than $25 million. Contractor is required to report all overpayments in their annual report to DHCS, using the rate development template, including recoveries that are less than $25 million. Contractor does not need to report overpayments that are less than $25 million within 60 calendar days of when the overpayment was identified.

B. Annual Report

Contractor must annually report to DHCS its recoveries of overpayments using the rate development (42 CFR section 438.608(d)(3)).

1.3.7 Federal False Claims Act Compliance and Support

A. Employee Education about False Claims Recovery

Contractor must provide to all its employees, Subcontractors, Downstream Subcontractors, and Network Providers written policies containing detailed information about the False Claims Act and other federal and State laws

described in 42 United States Code (USC) section 1396a(a)(68), including information about rights of employees to be protected as whistleblowers (See also 42 CFR section 438.608(a)(6)).

Upon request by DHCS, Contractor must demonstrate compliance with this Exhibit A, Attachment III, Subsection 1.3.7.A (*Employee Education about False Claims Recovery*), which may include providing DHCS with copies of Contractor's applicable written policies and procedures and any relevant employee handbook excerpts.

B. Cooperation with the Office of the Attorney General, DMFEA, or the US DOJ Investigations and Prosecutions.

Contractor must fully cooperate in any investigation or prosecution conducted by the Office of the Attorney General, DMFEA or the US DOJ. Contractor's cooperation must include, but is not limited to, providing upon request, information, and access to records. Contractor is also responsible for making their staff available for in-person interviews, consultation, grand jury proceedings, pre-trial conference, depositions, and hearings at DHCS headquarters in Sacramento.

C. Money Recovered from State Action Belongs to the State

In the event that DHCS receives a monetary recovery from the Office of the Attorney General, DMFEA, or the US DOJ, as a result of DMFEA's or US DOJ's prosecution of a Subcontractor, Downstream Subcontractor, or Network Provider under the California False Claims Act (Government Code (GC) § 12650 *et seq.*), the Federal False Claims Act (31 USC section 3729 *et seq.*), or any other applicable laws, the entirety of such monetary recovery belongs exclusively to DHCS, and Contractor waives any claim to any portion of the recovery, except as determined by DHCS in its sole discretion.

D. Payment to Contractor is from Government Funds

Medi-Cal payments to Contractor, Subcontractors, Downstream Subcontractors, Network Providers, and Providers are made from federal and State government funds. DHCS retains the right to recover overpayments made to Contractor, Subcontractors, Downstream Subcontractors, Network Providers, and/or Providers of Medi-Cal services, medical supplies, or drugs as set forth in part in Exhibit B, Section 1.9 (*Recovery of Amounts Paid to Contractor*). In addition to DHCS' recovery rights, DMFEA and US DOJ may prosecute any act of health care Fraud involving such government funds under the California False Claims Act

(GC § 12650 *et seq.*), the Federal False Claims Act (31 USC section 3729 *et seq.*), or any other applicable laws.

E. Contractor's Settlements with Subcontractors, Downstream Subcontractors, and Network Providers do not bind DHCS, DMFEA, or the US DOJ.

Any settlement or resolution of a disputed matter involving Fraud, Waste, or Abuse between Contractor and its Subcontractor, Downstream Subcontractor, or Network Provider must include a written provision that provides notice to the Subcontractor, Downstream Subcontractor, or Network Provider that the settlement and/or resolution is not binding on DHCS, DMFEA, or the US DOJ and does not preclude DHCS, DMFEA, or the US DOJ from taking further action against Contractor or its Subcontractor, Downstream Subcontractor, or Network Provider.

Exhibit A, ATTACHMENT III

2.0 Systems and Processes

DHCS is committed to ensuring Contractors have the capabilities, systems and processes that enable delivery of high-quality health care. The provisions in this Article lay out DHCS' expectations of Contractors to have Management Information Systems (MIS) to collect, report, and analyze data to identify Members' needs and support Population Health Management. Contractors must be able to not only submit Encounter Data, but have systems to ensure the data are complete, accurate, reasonable, and timely, including for Subcontractors, Downstream Subcontractors, and Network Providers.

The provisions of this Article are also intended to ensure that Medi-Cal systems and processes are innovative and adapting to the way in which Members seek and access care. DHCS expects Contractors to build upon their MIS capabilities to enable interoperability for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) Networks. Further, Contractors must comply with the Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access Final Rule set forth at CMS-9115-F and ensure that they and their Subcontractors, Downstream Subcontractors, and Network Providers have the system capabilities to comply with the California Health and Human Services Data Exchange Framework set forth in H&S section 130290. These requirements will enable the delivery system to have information for Members where and when they need care.

To further drive standards of high quality care and Health Equity, this Article includes provisions requiring Contractors to have both National Committee for Quality Assurance (NCQA) Health Plan Accreditation and Health Equity Accreditation by January 1, 2026. Further, DHCS specifies alignment of Quality Improvement and Health Equity activities that align in principle with the DHCS Comprehensive Quality Strategy and imposes requirements for Contractors to meet or exceed minimum performance standards.

DHCS is committed to transparency to demonstrate accountability to the public and community it serves. Consequently, DHCS requires public reporting of information related to access, quality, delegation, quality improvement, and Health Equity activities. Specific to public posting, this Article includes provisions requiring Contractors to make available on their websites their annual Quality Improvement and Health Equity Transformation Plan, meeting minutes from their Quality Improvement and Health Equity Committee (QIHEC), and Utilization Management policies and procedures.

2.1 Management Information System

2.1.1 Management Information System Capability
2.1.2 Encounter Data Reporting
2.1.3 Participation in the State Drug Rebate Program
2.1.4 Network Provider Data Reporting
2.1.5 Program Data Reporting
2.1.6 Template Data Reporting
2.1.7 Management Information System/Data Audits
2.1.8 Management Information System/Data Correspondence
2.1.9 Tracking and Submitting Alternative Format Selections
2.1.10 Interoperability Application Programming Interface System Requirements

2.1 Management Information System

2.1.1 Management Information System Capability

Contractor's Management and Information System (MIS) must be fully compliant with 42 Code of Federal Regulations (CFR) section 438.242 requirements and must have the capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data quality and timeliness requirements of DHCS's Encounter Data submission. Contractor must make available to DHCS and to the Centers for Medicare & Medicaid Services (CMS) upon request all data related to this Contract.

A. Contractor must have and maintain a MIS that supports, at a minimum:

1) All Medi-Cal eligibility data;

2) Information on Members enrolled with Contractor,

3) Provider claims status and payment data;

4) Health care services delivery Encounter Data;

5) Network Provider Data;

6) Program Data;

7) Template Data;

8) Screening and assessment data;

9) Referrals including tracking of referred services to follow up with Members to ensure that services were rendered;

10) Electronic health records;

11) Prior Authorization requests and a specialty referral system as specified in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*);

12) Complex Care Management (CCM) Care Manager assignment as specified in Exhibit A, Attachment III, Subsection 4.3.7 *(Care Management Programs*);

13) Financial information as specified in Exhibit A, Attachment III, Subsection 1.2.2 (*Contractor's Financial Reporting Obligations*);

14) Social Drivers of Health (SDOH) data per All Plan Letter (APL) 21-009;

15) Member and Member's Authorized Representative (AR) Alternative Format Selection(s) (AFS); and

16) Data sources specified in DHCS policies and guidance, including APLs, the Enhanced Care Management (ECM) Policy Guide, Community Supports Policy Guide, the Population Health Management (PHM) Policy Guide, and the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Re-entry Initiative.

B. Contractor's MIS must have processes that support the interactions between financial data, Member/eligibility data, Network Provider Data, Encounter Data, claims data, Program Data, Template Data, quality management/quality improvement/Utilization Management data, and report generation subsystems. The interactions of Contractor's MIS subsystems must be interoperable, efficient, and successful with Contractor's other MIS subsystems and DHCS' systems and processes.

C. Contractor's MIS must have the capability to transmit and consume data files with and from DHCS, Subcontractors, Downstream Subcontractors, Network Providers, other State and federal and local governmental agencies, and other sources as needed to support Care Coordination and overall administration of the Medi-Cal program. Data that must be able to be transmitted and consumed include, but are not limited to:

1) Encounter Data;

2) Fee-For-Service (FFS) claims data; including carved-out claims data, such as Medically Necessary services carved out of this Contract and data available from partner organizations, including but not limited to the Local Education Agency Medi-Cal Billing Option Program (LEA BOP) and incarceration in-reach services;

3) Dental claims data;

4) Specialty mental health data;

5) Substance Use Disorder (SUD) data;

Back to Agenda Back to Item

6) Medi-Cal FFS Treatment Authorization Request data;

7) California Children's Services (CCS) Program data;

8) Targeted Case Management (TCM) data;

9) Pharmacy claims data;

10) Risk Tier assignment data;

11) Authorization and referral data; and

12) Medical record information including case notes.

Contractor must have processes in place for utilizing all data made available in order to meet the requirements for and support of Care Coordination, other administrative functions of the Contract with DHCS, and Operational Readiness Requirements and Deliverables as described in Exhibit A, Attachment II.

D. Contractor must implement and maintain a publicly accessible, standards-based Patient Access Application Programming Interface (API), and a Provider Directory API, as described in 42 CFR sections 431.60 and 431.70, and in APL 22-026. Contractor must operate the API in the manner specified in 45 CFR section 170.215 and include information per 42 CFR section 438.242(b)(5) and (6).

2.1.2 Encounter Data Reporting

A. Contractor must maintain a MIS that consumes Encounter Data and/or claims data and transmits Encounter Data, including allowed amounts and paid amounts as required, to DHCS in compliance with 42 CFR sections 438.242 and 438.818 and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Encounter Data to DHCS, as defined in State and federal law, APLs, and this Contract, for all items and services furnished to a Member under this Contract, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers to submit

claims and Encounter Data to Contractor to ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Encounter Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, Downstream Subcontractor, and out-of-Network Provider Encounter Data regardless of contracting arrangements or whether the Network Provider, Subcontractor, Downstream Subcontractor, or out-of-Network Provider is reimbursed on a FFS or capitated basis.

D. Contractor must submit complete, accurate, reasonable, and timely Encounter Data within six Working Days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS.

E. DHCS will review and validate Contractor's Encounter Data, including Encounter Data submitted by Contractor on behalf of its Subcontractors, Downstream Subcontractors, and Network Providers, for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Encounter Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Encounter Data, Contractor must ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Encounter Data.

G. DHCS or its agent will periodically, but not less frequently than once every three years, conduct an independent audit of the Encounter Data submitted by, or on behalf of, Contractor, in accordance with 42 CFR section 438.602(e). Contractor must comply with the requirements set forth in Exhibit A, Attachment III, Subsection 2.2.9.E (*Encounter Data Validation*).

2.1.3 Participation in the State Drug Rebate Program

A. Contractor must participate in the federal and State drug rebate program by including all utilization data for both current and retroactive outpatient drugs in its Encounter Data as necessary to meet federal requirements in 42 United States Code (USC) section 1396r - 8(k)(2).

1) Encounter Data for outpatient drugs must comply with 42 USC section 1396r - 8(b)(1)(A); and

2) All outpatient drug Encounter Data must include, at a minimum, the total number of units of each dosage form, strength, and package size, by 11 numeric digit National Drug Code (NDC), for each claim, including eligible Physician administered drug claims.

B. Pursuant to 42 CFR section 438.3(s), Contractor must ensure that Encounter Data for outpatient drugs from participating organizations or covered entities in the federal 340B program contains DHCS-required identifiers to maintain compliance with the requirements of 42 USC section 256b(a)(5)(A)(i). Contractor must also comply with the provisions of Welfare and Institutions Code (W&I) section 14105.46.

C. Contractor must assist DHCS in resolving manufacturer rebate disputes related to Network Provider Data or Encounter Data submissions. Encounter Data identified by DHCS or Contractor as having inaccurate or incomplete units, NDCs, procedure codes, 340B identifiers, or other data elements necessary to resolve manufacturer drug rebate disputes are required to be corrected and resubmitted in compliance with APLs.

2.1.4 Network Provider Data Reporting

A. Contractor must maintain a MIS that collects and transmits Network Provider Data to DHCS in compliance with 42 CFR sections 438.207, 438.604(a)(5), and 438.606, and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Network Provider Data, Subcontractor data, and Downstream Subcontractor data to DHCS, as defined in State and federal law, APLs, DHCS 274 companion guide, and this Contract, that accurately represents Contractor's Network, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, and Downstream Subcontractors to submit Network Provider Data to Contractor to ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Network Provider Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and

timeliness of all Network Provider, Subcontractor, and Downstream Subcontractor Network Provider Data regardless of contracting arrangements.

D. Contractor must submit complete, accurate, reasonable, and timely Network Provider Data within ten calendar days following the end of each month, or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Network Provider Data as set forth in 42 CFR section 438.606. Subcontractors, Downstream Subcontractors and Network Providers must comply with this Section for submission of Network Provider Data to Contractor.

E. DHCS will review and validate Contractor's Network Provider Data for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Network Provider Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Network Provider Data, Contractor must ensure that corrected Network Provider Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Network Provider Data.

2.1.5 Program Data Reporting

A. Contractor must maintain a MIS that consumes and transmits Program Data to DHCS in compliance with Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Program Data to DHCS, as defined in State and federal law, APLs, and this Contract, including, but not limited to, all Grievances, Appeals, referrals, out-of-Network requests, medical exemption request denial reports and other continuity of care requests, and Primary Care Provider (PCP) and Risk Tier assignments received or determined by Contractor, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers to submit

Back to Agenda Back to Item

Program Data to Contractor to ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Program Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, Downstream Subcontractor, and out-of-Network Provider Program Data regardless of contracting arrangements.

D. Contractor must submit complete, accurate, reasonable, and timely Program Data within ten calendar days following the end of each month, or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Program Data as set forth in 42 CFR section 438.606. Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers must comply with this Subsection for submission of Program Data to Contractor.

E. DHCS will review and validate Contractor's Program Data for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Program Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Program Data, Contractor must ensure that corrected Program Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Program Data.

2.1.6 Template Data Reporting

A. Contractor must maintain a MIS that collects and reports Template Data to DHCS in compliance with Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Template Data to DHCS, as defined in State and federal law, APLs, and this Contract, for all items and services furnished to a Member under this Contract, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, and Downstream Subcontractors to submit Template Data to Contractor to

Back to Agenda Back to Item

ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Template Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, and Downstream Subcontractor Template Data regardless of contracting arrangements.

D. Contractor must submit complete, accurate, reasonable, and timely Template Data on a regular basis, or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Template Data as set forth in 42 CFR section 438.606. Subcontractors, Downstream Subcontractors, and Network Providers must comply with this Subsection for submission of Template Data to Contractor.

E. DHCS will review and validate Contractor's Template Data for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Template Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Template Data, Contractor must ensure that corrected Template Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Template Data.

2.1.7 Management Information System/Data Audits

Contractor must conduct MIS and data audits to the extent directed by DHCS, in accordance with this Contract, APLs, or other similar instructions which will be no less frequently than once every three years.

2.1.8 Management Information System/Data Correspondence

When DHCS provides Contractor with written notice of any problems or deficiencies related to the submittal of data to DHCS, or of any changes or clarifications related to Contractor's MIS system, Contractor must submit to DHCS a Corrective Action plan with measurable benchmarks within 15 calendar days from the date of DHCS' written notice to Contractor. DHCS will approve Contractor's Corrective Action plan or request revisions within 30 calendar days of receipt of Contractor's Corrective Action plan. If DHCS requests revisions, Contractor must submit a revised Corrective Action plan for DHCS' approval within 15 calendar days after receipt of the request. Contractor's failure to

complete the Corrective Action plan as approved by DHCS will subject it to sanctions, pursuant to Exhibit E, Section 1.19 (*Sanctions*). DHCS may publicly disclose on the DHCS website any Contractors that have entered into Corrective Action plans or have been subject to sanctions due to non-compliance under this Section.

2.1.9. Tracking and Submitting Alternative Format Selections

A. Contractor must have and maintain systems that are able to, at a minimum, perform the following functions:

1) Collect and store Member Alternative Format Selection (AFS), as well as the AFS of a Member's AR;

2) Share Member AFS data with DHCS as specified in the Alternative Format Data Process Guide included in APL 22-002; and

3) Track Member's AR AFS data and submit to DHCS when requested.

B. Contractor must submit all Member AFS data that has been collected in a one-time file upload to the DHCS Alternate Formats database, in the time and manner specified in APL 22-002.

C. After Contractor's one-time file upload is completed, Contractor must submit to DHCS all new Member AFS at the time of the Member's request. Contractor must send submissions online through the AFS application system, or by calling the AFS Helpline at (833) 284-0040.

D. DHCS will share Member AFS data with Contractor on an ongoing basis. DHCS will send Contractor a weekly AFS file from the DHCS Alternative Format Database. The DHCS weekly file data elements and file path are included in the APL 22-002 AFS Technical Guidance attachment. Contractor must utilize the weekly DHCS AFS file data to update their records and provide Member materials in the requested alternative formats.

E. Contractor must submit to DHCS policies and procedures for collecting and sharing AFS data in accordance with the requirements in APL 22-002.

2.1.10 Interoperability Application Programming Interface System Requirements

A. In order to ensure Contractor applies the same standards for Encounter Data contained in Exhibit A, Attachment III, Section 2.1.2 (*Encounter Data*

Back to Agenda Back to Item

Reporting), to data collected and made available through its API, Contractor must verify that data collected from Network Providers, Subcontractors, and Downstream Subcontractors to be made available through the API is complete, accurate, reasonable, and timely, and collected in accordance with the oversight and monitoring requirements in APL 22-026. Contractor must make all collected data available to DHCS and CMS, upon request.

B. Contractor must conduct routine testing and monitoring of its API functions, and applying system updates as appropriate, to ensure that the API is compliant and functional.

C. Contractor may deny or discontinue any third-party application connection to its API if Contractor determines that continued access presents an unacceptable level of risk to the security of protected health information on its systems. Contractor's determination must be made in accordance with the requirements provided in APL 22-026.

Back to Agenda Back to Item

Exhibit A, ATTACHMENT III

2.2 Quality Improvement and Health Equity Transformation Program

2.2.1 Quality Improvement and Health Equity Transformation Program Overview
2.2.2 Governing Board
2.2.3 Quality Improvement and Health Equity Committee
2.2.4 Provider Participation
2.2.5 Subcontractor and Downstream Subcontractor Quality Improvement Activities
2.2.6 Quality Improvement and Health Equity Transformation Program Policies and Procedures
2.2.7 Quality Improvement and Health Equity Annual Plan
2.2.8 National Committee for Quality Assurance Accreditation
2.2.9 External Quality Review Requirements
2.2.10 Quality Care for Children
2.2.11 Skilled Nursing Facilities—Long-Term Care
2.2.12 Disease Surveillance
2.2.13 Credentialing and Recredentialing

2.2 Quality Improvement and Health Equity Transformation Program

Contractor must implement a Quality Improvement and Health Equity Transformation Program (QIHETP) that includes, at a minimum, the standards set forth in 42 Code of Federal Regulations (CFR) sections 438.330 and 438.340, and 28 California Code of Regulations (CCR) section 1300.70, and be consistent with the principles outlined in the DHCS Comprehensive Quality Strategy and and a forthcoming All Plan Letter (APL). Contractor must monitor, evaluate, and take timely action to address necessary improvements in the Quality of Care delivered by all its Providers in any setting, and take appropriate action to improve upon Health Equity. Contractor is responsible for the quality and Health Equity of all Covered Services regardless of whether or not those services have been delegated to a Subcontractor, Downstream Subcontractor, or Network Provider.

A. Contractor must deliver quality care that enables all its Members to maintain health and improve or manage a chronic illness or disability. Contractor must ensure quality care in each of the following areas:

   1) Clinical quality of physical health care;

   2) Clinical quality of Behavioral Health care focusing on prevention, recovery, resiliency, and rehabilitation;

   3) Access to primary and specialty health care Providers and services;

   4) Availability and regular engagement with Primary Care Providers (PCP);

   5) Continuity of care and Care Coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent Provider-patient relationships; and

   6) Member experience with respect to clinical quality, access and availability, culturally and linguistically competent health care and services, continuity of care, and Care Coordination.

B. Contractor must apply the principles of continuous quality improvement (CQI) to all aspects of Contractor’s service delivery system through analysis, evaluation, and systematic enhancements of the following:

   1) Quantitative and qualitative data collection and data-driven decision-making;

2) Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

3) Feedback provided by Members, community partners, and Network Providers in the design, planning, and implementation of its CQI activities; and

4) Other issues identified by Contractor or DHCS.

C. Contractor must develop Population Health Management interventions designed to address Social Drivers of Health (SDOH), reduce disparities in health outcomes experienced by different subpopulations of Members, and work towards achieving Health Equity by:

1) Developing equity-focused interventions intended to address disparities in the utilization and outcomes of physical and Behavioral Health care services; and

2) Engaging in a Member and family-centric approach in the development of interventions and strategies, and in the delivery of all health care services.

D. Contractor must ensure that the QIHETP requirements of this Contract are applied to the delivery of both physical and Behavioral Health Services.

2.2.1 Quality Improvement and Health Equity Transformation Program Overview

Contractor must maintain a QIHETP which includes the following, at a minimum:

A. Oversight and participation of Contractor's Governing Board;

B. Creation and designation of a Quality Improvement and Health Equity Committee (QIHEC) whose activities are supervised by Contractor's medical director or the medical director's designee, in collaboration with Contractor's Chief Health Equity Officer;

C. Supervision of QIHETP activities by Contractor's medical director and the Chief Health Equity Officer; and

D. The participation of a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, Community Health

Workers (CHWs), and other non-clinical Providers in the process of QIHETP development and performance review.

2.2.2 Governing Board

Contractor must implement and maintain written policies and procedures that specify the responsibilities of its Governing Board, which include the following, at a minimum:

A. Approving the overall QIHETP and the annual plan of the QIHETP;

B. Appointing an accountable entity or entities within Contractor's organization responsible for the oversight of the QIHETP;

C. Receiving written QIHEC progress reports that describe actions taken, progress in meeting QIHETP objectives, and improvements made; and

D. Directing necessary modifications to QIHETP policies and procedures to ensure compliance with the Quality Improvement (QI) and Health Equity standards in this Contract and the DHCS Comprehensive Quality Strategy.

2.2.3 Quality Improvement and Health Equity Committee

A. Contractor must implement and maintain a Quality Improvement and Health Equity Committee (QIHEC) designated and overseen by its Governing Board. Contractor's medical director or the medical director's designee must head QIHEC in collaboration with Contractor's Chief Health Equity Officer. Contractor must ensure that a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, Subcontractors, Downstream Subcontractors, Network Providers, and Members, actively participate in the QIHEC or in any sub-committee that reports to the QIHEC. The Subcontractors, Downstream Subcontractors, and Network Providers that are part of QIHEC must be representative of the composition of Contractor's Network and include, at a minimum, Network Providers who provide health care services to Members affected by Health Disparities, Limited English Proficiency (LEP) Members, Children and Youth with Special Health Care Needs (CYSHCN), Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions.

The QIHEC's responsibilities include the following:

1) Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other Contractor committees such as the Community Advisory Committee (CAC);

2) Institute actions to address performance deficiencies, including policy recommendations; and

3) Ensure appropriate follow-up of identified performance deficiencies.

B. Contractor must ensure Member confidentiality is maintained in QI discussions and ensure avoidance of conflict of interest among the QIHEC members.

C. Contractor must ensure that the QIHEC meets at least quarterly, and more frequently if needed. A written summary of QIHEC activities, as well as QIHEC activities of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, findings, recommendations, and actions must be prepared after each meeting and submitted to Contractor's Governing Board. Contractor must also submit the written summary to DHCS quarterly.

D. Contractor must make the written summary of the QIHEC activities publicly available on Contractor's website at least on a quarterly basis.

E. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors maintain a QIHEC that meets the requirements set forth in this Section. Contractor must also ensure that they report to Contractor's QIHEC quarterly, at a minimum.

2.2.4 Provider Participation

Contractor must ensure that its Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors participate in the QIHETP and Population Needs Assessment (PNA) as described in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*). Contractor must incorporate its Fully Delegated Subcontractor and Downstream Fully Delegated Subcontractor data and results into the development of its PNA, as described in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*). Contractor must regularly update its Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors on activities, findings, and recommendations of the QIHEC's QIHETP and PNA results.

2.2.5 Subcontractor and Downstream Subcontractor Quality Improvement Activities

A. Contractor is accountable for all QI and Health Equity functions and responsibilities that are delegated to Subcontractors and any Downstream Subcontractors, in accordance with Exhibit A, Attachment III, Subsection 3.1.1 (*Overview of Contractor's Duties and Obligations*). Contractor must, at a minimum, specify the following requirements in its Subcontractor Agreements and Downstream Subcontractor Agreements, as applicable:

1) QI or Health Equity responsibilities, and specific subcontracted functions and activities of Subcontractor and Downstream Subcontractor;

2) The schedule for Contractor's ongoing oversight, monitoring, and evaluation of Subcontractor and Downstream Subcontractor, including quarterly reporting and an annual review of Subcontractor's and Downstream Subcontractor's performance;

3) Subcontractor's and Downstream Subcontractor's reporting requirements and Contractor's approval procedure of Subcontractor's and Downstream Subcontractor's reports;

4) Subcontractor's and Downstream Subcontractor's obligation to report findings and actions of QI or Health Equity activities at least quarterly to Contractor; and

5) Contractor's actions and remedies if Subcontractor's and Downstream Subcontractor's obligations are not satisfactorily performed.

B. Contractor must maintain an adequate oversight procedure to ensure Subcontractor's and Downstream Subcontractor's compliance with all QI or Health Equity delegated activities that, at a minimum:

1) Evaluates Subcontractor's and Downstream Subcontractor's ability to perform the delegated activities, including an initial determination that Subcontractor and Downstream Subcontractor have the administrative capacity, experience, and budgetary resources to fulfill their contractual obligations;

2) Ensures Subcontractor and Downstream Subcontractor meet QI and Health Equity standards set forth in this Contract; and

3) Includes Contractor's continuous monitoring, evaluation and approval of its delegated functions to Subcontractor and Downstream Subcontractor. Contractor must make the findings of its continuous monitoring and evaluation of the Subcontractor and Downstream Subcontractor available to DHCS at least annually, but more frequently when directed by DHCS.

2.2.6 Quality Improvement and Health Equity Transformation Program Policies and Procedures

Contractor must develop, implement, maintain, and periodically update its QIHETP policies and procedures that include, at a minimum, the following:

A. Contractor's commitment to the delivery of quality and equitable health care services;

B. Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's organizational chart, listing the key staff and the committees responsible for QI and Health Equity activities, including reporting relationships of QIHEC to executive staff;

C. Qualification and identification of staff who are responsible for QI and Health Equity activities;

D. A process for sharing QIHETP findings with its Subcontractors, Downstream Subcontractors, and Network Providers;

E. The role, structure, and function of the QIHEC;

F. The policies and procedures to ensure that all Covered Services are available and accessible to all Members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, health status, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner;

G. The policies and procedures designed to identify, evaluate, and reduce Health Disparities, by performing the following:

1) Analyzing data to identify differences in Quality of Care and utilization, as well as the underlying reasons for variations in the provision of care to its Members;

2) Developing equity-focused interventions to address the underlying factors of identified Health Disparities, including SDOH; and

3) Meeting disparity reduction targets for specific populations and/or measures as identified by DHCS and as directed under Exhibit A, Attachment III, Subsection 2.2.9.A (*Quality Performance Measures*).

H. Description of the integration of Utilization Management (UM) activities into the QIHETP as specified in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*), including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to the medical director or the medical director's designee;

I. Policies and procedures to adopt, disseminate, and monitor the use of clinical practice guidelines that:

1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field;

2) Consider the needs of Members;

3) Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified Providers from appropriate specialties;

4) Have been reviewed by Contractor's medical director, as well as Subcontractors, Downstream Subcontractors, and Network Providers, as appropriate; and

5) Are reviewed and updated at least every two years;

J. The inclusion of Population Health Management (PHM) activities, including the findings of the annual PNA, as required in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*);

K. Policies and procedures that ensure the delivery of Medically Necessary non-specialty and Specialty Mental Health Services as outlined in Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*);

L. Policies and procedures that ensure that Contractor and its Subcontractors, Downstream Subcontractors, Network Providers, and other entities with which Contractor contracts for the delivery of health care services comply with all mental health parity requirements in 42 CFR section 438.900 *et seq*.;

M. Mechanisms to detect both over- and under-utilization of services including, but not limited to, outpatient Prescription Drugs;

N. Mechanisms to continuously monitor, review, evaluate, and improve access to and availability of all Covered Services. The mechanisms must include oversight processes that ensure Members are able to obtain Medically Necessary appointments within established standards for time or distance, timely access, and alternative access in accordance with APL 23-001, and Welfare and Institutions Code (W&I) sections 14197 and 14197.04;

O. Mechanisms to continuously monitor, review, evaluate, and improve quality and Health Equity of clinical care services provided, including, but not limited to, preventive services for Children and adults, perinatal care, Primary Care, specialty, emergency, inpatient, Behavioral Health and ancillary care services; and

P. Mechanisms to continuously monitor, review, evaluate, and improve coordination and continuity of care services to all Members, including SPDs, C**Y**SHCNs, Members with chronic conditions, including Behavioral Health, Members experiencing homelessness, Members recently released from incarceration, Members who use Long-Term Services & Supports (LTSS), and Children receiving Child welfare services.

2.2.7 Quality Improvement and Health Equity Annual Plan

Through regional quality and health equity teams, Contractor must develop and submit an annual QI and Health Equity plan to DHCS, as directed below and in and a forthcoming APL.

A. Develop QI and Health Equity plan annually for submission to DHCS that includes the following, at a minimum:

1) A comprehensive assessment of the QI and Health Equity activities undertaken, including an evaluation of the effectiveness of QI interventions;

Back to Agenda Back to Item

2) A written analysis of required Quality Performance Measure results, and a plan of action to address performance deficiencies, including analyses of each Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's performance measure results and actions to address any deficiencies;

3) An analysis of actions taken to address any Contractor-specific recommendations in the annual External Quality Review (EQR) technical report and Contractor's specific evaluation reports;

4) An analysis of the delivery of services and Quality of Care of Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, based on data from multiple sources, including quality performance results, Encounter Data, Grievances and Appeals, Utilization Review and the results of consumer satisfaction surveys;

5) Planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and Behavioral Health care services;

6) A description of Contractor's commitment to Member and/or family focused care through Member and community engagement such as review of CAC findings, Member listening sessions, focus groups or surveys, and collaboration with local community organizations; and how Contractor utilizes the information from this engagement to inform Contractor policies and decision-making;

7) PHM activities and findings as outlined in Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*); and

8) Outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives.

To the extent that Contractor delegates its QI and Health Equity activities to its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, Contractor's QI and Health Equity annual plan must include evaluation and findings specific to the Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's performance.

B. Provide annual copies of all final reports of independent private accrediting agencies (e.g. the National Committee for Quality Assurance

(NCQA)) relevant to Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's Medi-Cal line of business, including:

1) Accreditation status, survey type, and level, as applicable;

2) Accreditation agency results, including recommended actions or improvements, Corrective Action plans, and summaries of findings; and

3) Expiration date of the accreditation.

In addition, pursuant to 42 CFR section 438.332, Contractor must authorize independent private accrediting agencies to provide DHCS a copy of Contractor's most recent accreditation review annually.

C. Provide an annual report to DHCS that includes an assessment of all Subcontractors' and Downstream Subcontractors' performance of its delegated QI or Health Equity activities.

D. Contractor must make the QI and Health Equity plan publicly available on its website on an annual basis.

E. Contractor must attend regional collaborative meetings which may include additional regional partners including but not limited to county Mental Health Plans (MHPs), Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), Local Government Agencies, public hospitals, and community-based organizations (CBOs).

2.2.8 National Committee for Quality Assurance Accreditation

Contractor must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by no later than January 1, 2026. Contractor must maintain full NCQA HPA and Health Equity Accreditation throughout the term of this Contract and submit every 3 years NCQA Health Plan Accreditation and Health Equity Accreditation results. Contractor must also complete additional NCQA accreditation programs as directed by DHCS.

In accordance with W&I section 14184.203, Contractor must also ensure that all its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors have full NCQA HPA and Health Equity Accreditation by no later than January 1, 2026. Contractor must also ensure all its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors maintain full NCQA HPA and Health Equity Accreditation throughout the term of this Contract.

Back to Agenda Back to Item

Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also complete additional NCQA accreditation programs as directed by DHCS.

Contractor must provide DHCS with the following components of Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's NCQA HPA and Health Equity Accreditation status and reviews within 30 calendar days of the receipt of the completed report from NCQA:

A. Accreditation status;

B. Survey type;

C. Results of the review;

D. Healthcare Effectiveness Data and Information Set (HEDIS ®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS ®) summary level data;

E. Recommended actions or improvements;

F. Corrective Action plans and summaries of findings; and

G. Expiration date of the accreditation.

Contractor must notify DHCS of the date of its NCQA site visit within 15 calendar days of confirmation of the site visit by NCQA. Contractor must make available all written materials submitted to NCQA available to DHCS and allow DHCS representative(s) to participate in the NCQA audit activities, including but not limited to, the NCQA site visit.

Contractor must notify DHCS of any change in NCQA HPA and Health Equity Accreditation status within 30 calendar days of receipt of the final NCQA report. In addition to complying with the Corrective Actions imposed by NCQA, Contractor must also comply with any additional Corrective Actions imposed by DHCS to address a change in Contractor's accreditation status.

If Contractor fails to obtain or maintain its HPA or Health Equity Accreditation status within the timeframe described above and anytime thereafter, Contractor will be subject to Corrective Actions by DHCS, including but not limited to, the actions set forth in Exhibit E, Sections 1.16 (*Termination*), 1.19 (*Sanctions*), and 1.20 (*Liquidated Damages*).

Contractor must have policies and procedures in place to oversee the HPA and Health Equity Accreditation status of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors throughout the term of this Contract. Contractor must have policies and procedures in place to subject its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors to Corrective Actions if Contractor's Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor fails to maintain its HPA and Health Equity Accreditation status, including, but not limited to, termination of Subcontractor Agreements or Downstream Subcontractor Agreements with Fully Delegated Subcontractors or Downstream Fully Delegated Subcontractors, sanctions, and damages.

2.2.9 External Quality Review Requirements

At least annually or more frequently as directed by DHCS, Contractor must cooperate with and assist the External Quality Review Organization (EQRO) designated by DHCS in conducting its EQR reviews of Contractor in accordance with 42 USC section 1396u-2(c)(2), 42 CFR section 438.310 *et seq.*, and 22 CCR section 53860(d).

Contractor must comply with all requirements set forth in 42 CFR section 438.310 *et seq*., the forthcoming APL, and the Centers for Medicare & Medicaid Services (CMS) EQR protocols, which provide detailed instructions on how to complete the EQR activities.

In addition, Contractor must also comply with the following requirements:

A. Quality Performance Measures

On an annual basis, Contractor must track and report on a set of Quality Performance Measures and Health Equity measures identified by DHCS in accordance with all of the following requirements:

1) Contractor must work with the EQRO to conduct an onsite assessment of the Quality Measure Compliance Audit and DHCS-required Quality Performance Measures;

2) Contractor must calculate and report all required Quality Performance Measures and Health Equity measures at the county or regional reporting unit level and possibly Skilled Nursing Facility (SNF) level as directed by DHCS. Contractor must separately report to DHCS all required performance measure results at the county or reporting unit level and SNF level for certain measures for

Back to Agenda Back to Item

its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors

a) Contractor must calculate performance measure rates, to be verified by the EQRO;

b) Contractor must report audited results on the required performance measures to DHCS no later than June 15 of each year or on another date as established by DHCS. Contractor must initiate reporting on required Quality Performance Measures for the reporting cycle following the first year of this Contract operation;

3) Contractor must meet or exceed the DHCS-established Minimum Performance Level (MPL) for each required Quality Performance Measure and Health Equity measure selected by DHCS. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors whose rates Contractor separately reports to DHCS also meet or exceed the DHCS-established MPL for each required Quality Performance Measure and Health Equity measure selected by DHCS.

4) Contractor must meet Health Disparity reduction targets for specific populations and measures as identified by DHCS.

5) In accordance with 42 CFR section 438.700 *et seq.*, W&I section 14197.7, and Exhibit E, DHCS may impose financial sanctions, administrative sanctions, and/or Corrective Actions on Contractor for failure to meet or exceed required MPLs as detailed in APL 23-012. DHCS may require Contractor to make changes to its executive personnel if a Contractor has persistent and pervasive poor performance as evidenced by multiple performance measures consistently below the MPL over multiple years. DHCS may also limit Contractor's Service Area expansion or suspend Member Enrollment based on Contractor's persistent and pervasive poor performance on Quality Performance Measures.

In addition to sanctions and Corrective Actions, DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider Contractor's performance on specified quality and equity benchmarks, as determined by DHCS and communicated to Contractors in advance of each applicable Rating Period, within the determination of Capitation Payment rates for that Rating Period.

Contractor is responsible for ensuring that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also meet or exceed the DHCS-established MPL. If its Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor fails to meet or exceed the DHCS-established MPL, Contractor must have policies and procedures in place to subject its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors to appropriate enforcement actions, which may include, but are not limited to, financial sanctions, corrective action plans, and a requirement to change its executive personnel.

B. PIPs

1) Contractor must conduct or participate in PIPs, including any PIP required by CMS, in accordance with 42 CFR section 438.330. Contractor must conduct or participate in, at a minimum, two (2) PIPs per year, as directed by DHCS. At its sole discretion, DHCS may require Contractor to conduct or participate in additional PIPs, including statewide PIPs. DHCS may also require Contractor to participate in statewide collaborative PIP workgroups.

2) Contractor must have policies and procedures in place to ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also conduct and participate in PIPs and any collaborative PIP workgroups as directed by CMS or DHCS.

3) Contractor must comply with the PIP requirements outlined in a forthcoming APL and must use the PIP reporting format as designated therein to request DHCS' approval of proposed PIPs.

4) Each PIP must include the following:

a) Measurement of performance using objective quality indicators;

b) Implementation of equity-focused interventions to achieve improvement in the access to and Quality of Care;

c) Evaluation of the effectiveness of the interventions based on the performance measures; and

d) Planning and initiation of activities for increasing or sustaining improvement.

5) Contractor must report the status of each PIP at least annually to DHCS.

C. Consumer Satisfaction Survey

1) On an annual basis until January 1, 2026, Contractor must timely provide all data requested by the EQRO in a format designated by the EQRO in conducting a consumer satisfaction survey.

2) Beginning January 1, 2026, concurrent with the requirement for HPA by the NCQA, Contractor must publicly post the annual results of its, and its Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's, CAHPS survey on Contractor's website, including results of any supplemental questions as directed by DHCS.

3) If Contractor has HPA prior to January 1, 2026 and reports its CAHPS data to the NCQA, Contractor must publicly post the annual results of its, and its Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's, CAHPS survey on Contractor's website, including results of any supplemental questions as directed by DHCS.

4) Contractor must incorporate results from the CAHPS survey in the design of QI and Health Equity activities.

D. Network Adequacy Validation

Contractor must participate in the EQRO's validation of Contractor's Network adequacy representations from the preceding 12 months to comply with requirements set forth in 42 CFR sections 438.14(b), 438.68, and 438.358.

E. Encounter Data Validation

As directed by DHCS, Contractor must participate in EQRO's validation of Encounter Data from the preceding 12 months to comply with requirements set forth in 42 CFR sections 438.242(d) and 438.818.

F. Focused Studies

As directed by DHCS, Contractor must participate in an external review of focused clinical and/or non-clinical topic(s) as part of DHCS' review of

quality outcomes and timeliness of, and access to, services provided by Contractor.

G. Technical Assistance

In accordance with 42 CFR section 438.358(d) and at the direction of DHCS, Contractor must implement EQRO's technical guidance provided to Contractor in conducting mandatory and optional activities described in 42 CFR section 438.358 and this Contract.

2.2.10 Quality Care for Children

Contractor must maintain a robust program to ensure the provision of all physical, behavioral, and oral health services to Members less than 21 years of age. Contractor must also maintain mechanisms to identify and improve on gaps in the quality of and access to care in each of the following areas:

A. Scope of Services

1) Contractor must ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members less than 21 years of age in accordance with Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*);

2) Contractor must actively promote Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings and American Academy of Pediatrics (AAP) Bright Futures preventive services to Members and their families. Per APL 23-005, on an annual basis by January 1 of each year, Contractor must mail or share electronically, DHCS Medi-Cal for Kids and Teens Materials for existing Members under the age of 21. For new Members, Contractor is required to mail or share electronically, DHCS Medi-Cal for Kids and Teens Materials within seven calendar days of the enrollment. Additionally, Contractor must ensure Network Providers receive standardized training on EPSDT utilizing the developed DHCS Medi-Cal for Kids and Teens Outreach and Education Toolkit;

3) Contractor must identify Members who have not utilized EPSDT screening services or AAP Bright Futures preventive services and ensure outreach to these Members in a culturally and linguistically appropriate manner;

4) Contractor must maintain Memorandums of Understanding (MOUs) with Local Health Departments (LHDs) and Local Government Agencies (LGAs), in Contractor's Service Area(s), including but not limited to California Children's Services (CCS), the Women, Infants and Children Supplemental Nutrition Program (WIC), maternal and Child health, social services, Regional Centers, and Child welfare departments, as outlined in Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) in order to facilitate the provision of EPSDT services to Members less than 21 years of age;

5) Contractor must comply with APL 23-005 requirements to include conducting ongoing training, at least once every two years, for Network Providers on required preventive healthcare services, including EPSDT services for Members less than 21 years of age as outlined in Exhibit A, Attachment III, Subsection 3.2.5.B (*Network Provider Training*), to ensure Providers are able to support Members and families in fully utilizing EPSDT services.

B. Utilization Management

Contractor must ensure that all requirements outlined in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*) apply to the review and provision of Medically Necessary services for Members less than 21 years of age.

C. Population Health Management (PHM) and Coordination of Care

1) Contractor must ensure that all requirements outlined in Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), including the development of the annual PNA, apply to Members less than 21 years of age;

2) Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must provide a comprehensive wellness and prevention program to all Members less than 21 years of age, which includes but is not limited to (see full requirements in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management))* initiatives, programs, and evidence-based approaches to improving access to preventive health visits, developmental screenings, and services for Members less than 21 years of age, as described in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*).

D. Network and Access to Care

1) Contractor must ensure that each Member less than 21 years of age has an assigned PCP as well as access to Specialists for Covered Services and Medically Necessary services, in accordance with Exhibit A, Attachment III, Subsection 5.2.1 (*Access to Network Providers and Covered Services*);

2) Contractor must provide information to all Network Providers regarding the Vaccines for Children (VFC) Program and is expected to promote and support Enrollment of applicable Network Providers in the VFC program in order to improve access to immunizations; and

3) Contractor must maintain and continually monitor, improve, and evaluate cultural and linguistic services that support the delivery of Covered Services to Members less than 21 years of age, in accordance with Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*).

E. Quality and Health Equity

1) Contractor must identify and address underutilization of Children's preventive services including but not limited to EPSDT services such as well Child visits, developmental screenings and immunizations;

2) Contractor must report on DHCS-identified Quality Performance Measures and Health Equity performance measures related to health care services for Members less than 21 years of age, and must exceed any DHCS-specified MPL, in accordance with Exhibit A, Attachment III, Subsection 2.2.9.A (*Quality Performance Measures*);

3) Contractor must engage with local entities when developing interventions and strategies to address deficiencies in performance measures related to health care services for Members less than 21 years of age;

4) Contractor must meet any Health Disparity reduction targets for specific populations and measures for Members less than 21 years of age, as identified by DHCS and in accordance with Exhibit A, Attachment III, Subsection 2.2.9.A.2 (*Quality Performance Measures*);

5) Contractor must participate in any value-based payment programs for services provided to Members less than 21 years of age, as directed by DHCS;

6) Contractor must engage in planned Health Equity-focused interventions to address identified gaps in the quality of and access to care for Members less than 21 years of age, including preventive and screening services; and

7) Contractor must engage in a Member and family-oriented engagement strategy to QI and Health Equity, including Children and caregiver representation on the Community Advisory Committee (CAC), and using CAC findings and recommendations, and the results of Member listening sessions, focus groups and surveys, to inform QI and Health Equity interventions, as outlined in Exhibit A, Attachment III, Subsection 5.2.11.D. (*Cultural and Linguistic Programs and Committees*).

F. Mental Health and Substance Use Disorder Services

Contractor must adhere to all requirements of Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*) for the provision of mental health and Substance Use Disorder services to Members less than 21 years of age, as appropriate, including collaborating with county Behavioral Health plans and complying with APL 23-010 and all mental health parity requirements in 42 CFR section 438.900 *et seq*.

Contractor must collaborate with DHCS in its effort to implement the California Children and Youth Behavioral Health Initiative.

G. School-Based Services

To facilitate the provision of Medically Necessary services to Children, Contractor must collaborate with, and, by January 1, 2025 execute, an MOU with Local Education Agencies (LEAs) in each county within Contractor's Service Area for school-based services, including but not limited to EPSDT and Behavioral Health Services for Members less than 21 years of age. Contractor must also ensure that Members' PCP (PCP) cooperate and collaborate with LEAs in the development of Individualized Education Plans (IEPs) or Individualized Family Service Plans (IFSPs) and ultimately ensure that care is coordinated regardless of financial responsibility, as outlined in Exhibit A, Attachment III, Subsections 4.3.16 (*School-Based Services*) and 5.6.1 (*MOU Purpose*).

2.2.11 Skilled Nursing Facilities – Long-Term Care

Contractor must implement and maintain policies and procedures for providing applicable Long-Term Care (LTC) services for Members as detailed in Exhibit A Attachment III, Subsection 5.3.7.G *(Services for All Members).* Contractors must maintain a comprehensive Quality Assurance Performance Improvement (QAPI) program for LTC services provided. Contractors must have a system in place to collect quality assurance and improvement findings from CDPH to include, but not be limited to, survey deficiency results, site visit findings, and complaint findings. Contractor's comprehensive QAPI program must incorporate all requirements in APL 23-004.

2.2.12 Disease Surveillance

Contractor must implement and maintain procedures for reporting any serious diseases or conditions to both local and State public health authorities and to implement directives from the public health authorities as required by law, including but not limited to, 17 CCR section 2500 *et seq*.

2.2.13 Credentialing and Recredentialing

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must implement and maintain written policies and procedures regarding the initial Credentialing, recredentialing, recertification, and reappointment of Network Providers in accordance with 42 CFR section 438.214 and APL 22-013. Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure its policies and procedures are reviewed and approved by its Governing Board. Contractor must ensure that the responsibility for recommendations regarding Credentialing decisions rests with a Credentialing committee or other peer review body.

A. Standards

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all their Network Providers who deliver Covered Services and have executed Network Provider Agreements with Contractor are qualified in accordance with current applicable legal, professional, and technical standards, and are appropriately licensed, certified, or registered.

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all their Network Providers have good standing in the Medicare and Medicaid/Medi-Cal programs and

have a valid National Provider Identifier (NPI) number. Contractor must ensure that Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's Network.

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all contracted Laboratory Testing Sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

B. Subcontractor and Downstream Subcontractor Credentialing

Contractor may delegate Credentialing and recredentialing activities, but Contractor remains ultimately responsible for the completeness and accuracy of these activities, as outlined in Exhibit A, Attachment III, Subsection 3.1.1 (*Overview of Contractor's Duties and Obligations*).

C. Credentialing Provider Organization Certification
Contractor may obtain Credentialing provider organization certification (POC) from the NCQA. Contractor may accept evidence of NCQA POC certification in lieu of a monitoring visit at Network Provider's facilities.

D. Disciplinary Actions

Contractor must implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner, including dentists, to the appropriate authorities. Contractor must implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating the privileges of practitioners, including dentists. Contractor must implement and maintain a Provider appeal process.

E. Medi-Cal and Medicare Provider Status

Contractor must verify that its Subcontractors, Downstream Subcontractors, and Network Providers have not been terminated as Medi-Cal or Medicare Providers or have not been placed under a restriction (payment or temporary suspension) resulting in placement on the Suspended and Ineligible Provider List, List of Excluded Entities, or Restricted Provider Database. Contractor cannot maintain contracts with Network Providers, Subcontractors, or Downstream Subcontractors who have been terminated by either Medicare or Medi-Cal or placed on the Suspended and Ineligible Provider List.

F. Contractor's NCQA Health Plan Accreditation

If Contractor has received an accredited status from NCQA, Contractor will be deemed to meet the DHCS requirements for Credentialing and may be exempt from the DHCS medical review audit for Credentialing.

G. Credentialing of Other Non-Physician Providers

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must develop and maintain policies and procedures that ensure that the credentials of Nurse Practitioners, Certified Nurse Midwives (CNMs), clinical nurse Specialists, Physician Assistants, mental health Providers, and substance use treatment Providers have been verified in accordance with State requirements applicable to the Provider category.

Exhibit A, ATTACHMENT III

2.3 Utilization Management Program

2.3.1 Prior Authorizations and Review Procedures
2.3.2 Timeframes for Medical Authorization
2.3.3 Review of Utilization Data
2.3.4 Delegating Utilization Management Activities

2.3 Utilization Management Program

Contractor must develop, implement, update as needed (but at least annually), and improve its Utilization Management (UM) program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services for its Members. Contractor must ensure that its UM program:

A. Includes a designated medical director or clinical director responsible for the UM process in accordance with Health & Safety Code (H&S) section 1367.01, and qualified staff responsible for the UM program.

B. Prohibits medical decisions to be influenced by fiscal and administrative management. Compensation of individuals or entities that conduct UM activities must not be structured to provide incentives to deny, limit, or discontinue Medically Necessary Covered Services.

C. Allows for a second opinion from a qualified health professional within the Network, if available. If a qualified health professional within the Network is not available, Contractor must authorize an out-of-Network Provider to provide the second opinion at no cost to the Member, in accordance with 42 Code of Federal Regulations (CFR) section 438.206.

D. Makes available to Network Providers all relevant UM policies and procedures upon request.

E. Makes available to Members all relevant UM policies and procedures upon request. Makes available to Members clinical criteria used by Contractor, Subcontractors, and Downstream Subcontractors, as applicable for assessing Medical Necessity for Covered Services.

F. Provides training to Network Providers on the procedures and services that require Prior Authorization for Medically Necessary Covered Services, and ensures that all Network Providers are aware of the procedures and timeframes necessary to obtain Prior Authorization for Medically Necessary Covered Services, within 30 calendar days of executing this Contract and within 30 calendar days of contracting with a Network Provider.

G. Has a Standing Referral process providing a determination within three Working Days from the date the request is made by the Member or the Member's Primary Care Providers (PCP) and all appropriate Medical Records and other items of information necessary to make the determination are provided. Once a determination is made, the referral must be made within four Working Days of the date that the proposed

treatment plan, if any, is submitted to Contractor's medical director or the medical director's designee, in accordance with H&S section 1374.16.

H. Has a specialty referral system to track and monitor referrals requiring Prior Authorization by Contractor. When Prior Authorization is delegated to Subcontractors and Downstream Subcontractors, Contractor must ensure that Subcontractors and Downstream Subcontractors have systems in place to track and monitor referrals requiring Prior Authorization and must furnish documentation of Subcontractor's and Downstream Subcontractor's referrals to DHCS upon request. Contractor's specialty referral systems must include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. Contractor's specialty referral systems must include information on requested out-of-Network services. Contractor must ensure that all Network Providers are aware of the specialty referral processes and tracking procedures.

I. Integrates UM activities into the Quality Improvement System (QIS) specified in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program (QIHETP)*), including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to the medical director or their designee.

J. Has timelines and processes that do not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and Substance Use Disorder (SUD) services than are imposed on medical/surgical services, in accordance with the parity in mental health and SUD requirements in 42 CFR section 438.900, et seq.

K. Makes Contractor's UM policies and procedures available to Members and Providers on Contractor's website and upon request. These policies and procedures must set out how Contractor authorizes, modifies, delays, or denies health care services via Prior Authorization, concurrent authorization, or Retrospective Review, under the services provided by Contractor in accordance with 42 CFR section 438.915.

1) Contractor must ensure that policies and procedures for authorization decisions are based on the Medical Necessity of a requested Covered Service and are consistent with criteria or guidelines supported by sound clinical principles and evidence-based practice.

2) Contractor must ensure that policies, processes, strategies, evidentiary standards, and other factors used for UM are consistently applied to medical/surgical, mental health, and SUD services and benefits.

3) Contractor must notify Network Providers, as well as Members and Potential Members upon request, of all services that require Prior Authorization, concurrent authorization, or Retrospective Review, and ensure that all Network Providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

All UM activities must be performed in accordance with H&S sections 1363.5 and 1367.01 and 28 California Code of Regulations (CCR) section 1300.70(a)(3), (b)(2)(H), and (c).

2.3.1 Prior Authorizations and Review Procedures

Contractor must ensure that its Prior Authorization, concurrent review, and Retrospective Review authorization procedures meet the following minimum requirements, in accordance with H&S section 1367.01:

A. Contractor must consult with Providers as needed for Prior Authorization requests for the purposes of determining Medical Necessity for Covered Services unless doing so would lead to undue delay in care;

B. Decisions to deny or to authorize an amount, duration, or scope that is less than requested must be made by a qualified health care professional with appropriate clinical expertise in treating the medical or Behavioral Health condition and disease or Long-Term Services and Supports (LTSS) needs. Appropriate clinical expertise may be demonstrated by relevant specialty training, experience, or certification. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions;

C. Qualified health care professionals must supervise the review of medical decisions, including service reductions, and must review all denials that are made, in whole or in part, based on Medical Necessity. Contractor is not responsible for the review of Prior Authorizations for physician administered drugs, medical supplies, enteral nutritional products, and covered outpatient Prescription Drugs provided by an outpatient pharmacy. Contractor must review Prior Authorizations for physician administered drugs which include Prescription Drugs administered by a health care professional in a clinic, physician’s office, or outpatient setting;

medical supplies; and enteral nutritional products. These Prescription Drugs and supplies are covered under the medical benefit and would be included in the medical claim or encounter;

D. Contractor must establish written criteria or guidelines for UM that are developed with practicing health care Providers. The written criteria or guidelines must be based on sound clinical practices and processes which are evaluated and updated when necessary, and at least annually, in accordance with H&S section 1363.5;

E. Contractor must provide a clear and concise written explanation of the reasons for denying, deferring, or modifying a service; a description of the criteria or guidelines used; and the clinical reasons for the decision based on Medical Necessity. Any written communication to a Provider of a denial, delay, or modification of a request must include the name and telephone number of Contractor's health care professional responsible for the denial, delay, or modification;

F. Contractor must notify Members regarding denied, deferred or modified referrals as specified in Exhibit A, Attachment III, Subsection 5.1.5, (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*). Contractor must publish on its website an Appeals procedure for both Providers and Members;

G. Decisions and Appeals must be made in a timely manner and not be unduly delayed when Member's medical condition requires time sensitive services;

H. Prior Authorization requirements must not be applied to Emergency Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, Human Immunodeficiency Virus (HIV) testing, or initial mental health and SUD assessments;

I. Records relating to Prior Authorization requests, including any Notices of Action (NOA), must meet the retention requirements described in Exhibit E, Section 1.22 (*Inspection and Audit of Records and Facilities*);

J. Contractor must notify the requesting Provider of any decision to deny, approve, modify, or delay a service authorization request, a request by a Member or a Member's Provider for the provision of a Covered Service, or when authorizing a service in an amount, duration, or scope that is less than requested. The notice to the Provider may be oral or in writing; and

Back to Agenda Back to Item

K. All of Contractor's authorization requirements must comply with the requirements for parity in mental health and SUD benefits in 42 CFR section 438.900, et seq.

2.3.2 Timeframes for Medical Authorization

A. Emergency Services: Contractor must not require Prior Authorization for Emergency Services for complaints or conditions that a prudent layperson would determine could seriously jeopardize their physical or mental health.

B. Post-Stabilization Care Services: Contractor must respond to a Network Provider's or out-of-Network Provider's request for authorization for Post-Stabilization Care Services within 30 minutes or the service is deemed approved, in accordance with All Plan Letter (APL) 23-009.

C. Non-Urgent Care Following an Exam in the Emergency Room: Contractor must respond to a Provider's request for Post-Stabilization Care Services within 30 minutes or the service is deemed approved.

D. Retrospective Review Authorization Request for Treatment Received: Contractor must accept requests for Retrospective Review authorization within a reasonably established time limit, not to exceed 365 calendar days from the date of service. Contractor must communicate decisions to the Provider and to the Member who received the services or to the Member's Authorized Representative (AR) within 30 calendar days of the receipt of information that is reasonably necessary to make this determination, in accordance with 42 CFR section 438.404(a) and H&S section 1367.01(h)(1).

E. Routine Authorizations: Contractor must respond to routine requests and concurrent requests as expeditiously as the Member's condition requires, but no longer than five Working Days from receipt of the information reasonably necessary and requested by Contractor to render a decision, and no longer than 14 calendar days from Contractor's receipt of the request, in accordance with 42 CFR section 438.210 and H&S section 1367.01.

F. Expedited Authorizations: Contractor must make expedited authorization decisions for service requests where a Member's Provider indicates, or Contractor, Subcontractor, Downstream Subcontractor, or Network Provider determines that, following the standard timeframe for Prior Authorizations and concurrent requests could seriously jeopardize the Member's life; health; or ability to attain, maintain, or regain maximum function, in accordance with 42 CFR section 438.210 and H&S section

1367.01. Contractor must provide its authorization decision as expeditiously as the Member's health condition requires, but no longer than 72 hours after Contractor's receipt of the request for services. All Contractors must also expedite Prior Authorization requests for Members who are transitioning from an acute care hospital to all settings including Contractor chosen Community Supports and make an authorization decision in a timeframe that is appropriate for the nature of the Member's condition but is no longer than 72 hours after Contractor's receipt of all information needed to make an authorization decision.

G. Hospice Services: Contractor may only require Prior Authorization for inpatient hospice care. Contractor must respond to inpatient hospice care authorization requests in accordance with 22 CCR section 51003 and APLs.

H. Therapeutic Enteral Formula: Contractor must comply with all timeframes for medical authorization of Medically Necessary therapeutic enteral formula billed on a medical or institutional claim and the equipment and supplies necessary for delivery of enteral formula billed on a medical or institutional claim, as set forth in all applicable DHCS APLs, Welfare and Institutions Code (W&I) section 14103.6, and H&S section 1367.01.

I. Physician Administered Drugs: ~~For medical authorization of Medically Necessary physician administered drugs billed on a medical or institutional claim, Contractor must comply with the same timeframes as other medical services, at set out in this subsection.~~ **Contractor must respond to requests for authorization of physician administered drugs billed on a medical or institutional claim within 24 hours of receipt of the request, in accordance with 42 USC section 1396r-8, 42 CFR sections 438.210 and 438.3, and W&I section 14185. If the physician administered drug is a "covered outpatient drug," as defined in 42 USC section 1396r-8(k)(2) and (k)(3), Contractor cannot obtain an extension of time to respond. However, if the physician administered drug is not a "covered outpatient drug," Contractor may obtain an extension of time to respond, as set forth in 42 CFR section 438.210**.

2.3.3 Review of Utilization Data

A. Contractor must include within the UM program mechanisms to detect both under- and over-utilization of health care services including Behavioral Health Services. Contractor's internal reporting mechanisms used to detect Member utilization and Provider prescribing patterns must

be reported to DHCS no later than 30 calendar days after the beginning of each calendar year and upon request.

B. Contractor must monitor utilization data to appropriately identify Members eligible for Enhanced Care Management (ECM) and applicable Community Supports as specified in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management)* and Subsection 4.5.6 (*Identifying Members for Community Supports)*.

C. Contractor must monitor and track Non-specialty Mental Health Services (NSMHS) utilization data for both Members. Upon request, Contractor must submit data to DHCS.

2.3.4 Delegating Utilization Management Activities

Contractor may delegate UM activities. If Contractor delegates any UM activities, Contractor must comply with Exhibit A, Attachment III, Subsection 2.2.5 (*Subcontractor and Downstream Subcontractor Quality Improvement Activities*).

Exhibit A, ATTACHMENT III

3.0 Providers, Network Providers, Subcontractors, and Downstream Subcontractors

DHCS is committed to ensuring that all Contractors are aware of their obligations under this Contract and are committed to being accountable not only for their own obligations, but for those of their Subcontractors and Downstream Subcontractors for delegated functions. In this Article, DHCS includes provisions requiring Contractors to disclose what entities provide delegated functions through Subcontractor Agreements and Downstream Subcontractor Agreements as applicable.

In addition, Contractors are to demonstrate that they have robust compliance, monitoring, and oversight programs, including for all delegated entities to ensure Members receive quality care and have access to services. This Article requires Contractors to not only disclose delegation arrangements but include justification for the use of delegated entities to ensure that the Member's experience and outcomes are front and center. DHCS is particularly focused on those entities that take risk; thus this Article includes provisions requiring reporting of Subcontractors and Downstream Subcontractors that assume responsibility for taking that risk and managing the health care of a portion of assigned lives.

This Article articulates DHCS' commitment in moving the delivery system towards value-based payment. Contractors are to report on the proportion of spend that is tied to value. In addition, Contractors are to implement Financial Arrangements that link payments to value in the form of higher quality of care, better health care outcomes, and lower cost of care. Such arrangements include, but are not limited to, incentive payment arrangements that reward Providers for high or improved performance on selected measures or benchmarks. Finally, Contractors are to report on the proportion of spend on Primary Care specifically in an effort to encourage investment in Primary Care as appropriate.

3.1 Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties

3.1.1 Overview of Contractor's Duties and Obligations
3.1.2 DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements
3.1.3 Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan
3.1.4 Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance
3.1.5 Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements
3.1.6 Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers
3.1.7 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Federally Qualified Health Centers and Rural Health Clinics
3.1.8 Network Provider Agreements with Safety-Net Providers
3.1.9 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments
3.1.10 Nondiscrimination in Provider Contracts
3.1.11 Public Records
3.1.12 Requirement to Post

Back to Agenda Back to Item

3.1 Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties

3.1.1 Overview of Contractor's Duties and Obligations

A. Contractor is fully responsible for all duties and obligations set forth in this Contract. However, Contractor may enter into agreements with other individuals, groups, or entities to fulfill its obligations and duties under the Contract, including Network Provider Agreements and Subcontractor Agreements. Some individuals, groups, or entities may be a combination of Network Provider, Subcontractor, and/or Downstream Subcontractor, in which case they would need to comply with the requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, as applicable. Subcontractors and Downstream Subcontractors may enter into agreements to fulfill their obligations and duties under the Contract, in which case they would need to comply with the requirements of Downstream Subcontractor Agreements or Network Provider Agreements, as applicable.

B. Contractor must ensure that all Subcontractors and Downstream Subcontractors comply with all Contract requirements related to the delegated functions undertaken by each Subcontractor or Downstream Subcontractor. Contractor remains fully responsible for the performance of all duties and obligations it delegates to Subcontractors and Downstream Subcontractors. To ensure Subcontractor's and Downstream Subcontractor's compliance, Contractor must, at a minimum, do the following:

1) Include all Contract duties and obligations relating to the delegated duties in the Subcontractor Agreement;

2) Ensure Subcontractor includes all Contract obligations relating to the delegated duties in all Downstream Subcontractor Agreements;

3) Provide policies and procedures to Subcontractors applicable to the delegated functions and ensure Subcontractor provides the relevant policies and procedures as applicable to delegated functions;

   Monitor and oversee all delegated functions, including those that may flow down to Downstream Subcontractors; and

4) Provide to DHCS a delegation reporting and compliance plan, as set forth in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's*

Back to Agenda Back to Item

Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan).

C. Contractor must ensure that Network Providers comply with all applicable Contract requirements and all requirements set forth in their Network Provider Agreements (See Exhibit A, Attachment III, Subsection 3.1.5.A (*Network Provider Agreement Requirements).*

3.1.2 DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements

A. Submission and Approval of Network Provider Agreements Templates

1) Contractor must submit to DHCS all Network Provider Agreement templates, and any proposed amendments thereto, for review and approval before use. The contents of the Network Provider Agreement templates are set forth in All Plan Letter (APL) 19-001.

2) Within 60 calendar days of receipt, DHCS will make all reasonable efforts to approve in writing the use of all Network Provider Agreement templates. DHCS will provide Contractor with a written explanation indicating whether the template is approved, disapproved, or an estimated date for completion of DHCS' review. If DHCS does not complete its review of Network Provider Agreement templates within 60 calendar days of receipt, or within DHCS' estimated date of completion, whichever is later, Contractor may elect to implement or use the material at Contractor's sole risk and subject to possible subsequent disapproval by DHCS.

B. Submission and Approval of Subcontractor Agreements and Downstream Subcontractor Agreements Templates

1) Contractor must submit to DHCS all Subcontractor Agreement and Downstream Subcontractor Agreement templates, and any amendments thereto, as follows:

a) For Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, Contractor must submit all Subcontractor Agreement and Downstream Subcontractor Agreement templates and any amendments thereto, to DHCS for review and approval before use. Contractor must also file with DHCS all executed Subcontractor Agreements with Fully Delegated Subcontractors and all executed

Back to Agenda Back to Item

Downstream Subcontractor Agreements with Downstream Fully Delegated Subcontractors.

b) For Partially Delegated Subcontractors and Administrative Subcontractors, and Downstream Partially Delegated Subcontractors and Downstream Administrative Subcontractors, Contractor must submit all Subcontractor Agreements and Downstream Subcontractor Agreements templates, and any amendments thereto, to DHCS for review and approval prior to execution of the Subcontractor Agreement or Downstream Subcontractor Agreement.

2) Within 60 calendar days of receipt, DHCS will make all reasonable efforts to approve in writing the use of Subcontractor Agreement and Downstream Subcontractor Agreement templates submitted by Contractor. DHCS will provide Contractor with a written explanation indicating whether the template is approved, disapproved, or an estimated date for completion of DHCS review. If DHCS does not complete its review of the submitted material within 60 calendar days of receipt, or by DHCS estimated date of completion, whichever is later, Contractor may elect to implement or use the template at Contractor's sole risk and subject to possible subsequent disapproval by DHCS.

3.1.3 Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan

A. Content of Delegation Reporting and Compliance Plan

Contractor must report its delegation and compliance plan using the templates provided in Exhibit J *(Delegation Reporting and Compliance Plan),* which includes, but is not limited to, the following:

1) All Contractor's contractual relationships with Subcontractors and Downstream Subcontractors;

2) Contractor's oversight responsibilities for all delegated obligations; and

3) How Contractor intends to oversee all delegated activities, including, but not limited to, details regarding key personnel who will be overseeing each delegated function.

B. Timing of Submission

Back to Agenda Back to Item

Contractor must submit its delegation reporting and compliance plan to DHCS as follows:

1) During the operational readiness period;

2) Annually, whether or not changes have been made to its delegation structure; and

3) Anytime there is a change in the delegation reporting and compliance plan, including but not limited to a change in a Subcontractor and/or a change in the scope of the delegation.

The report must be submitted within 30 calendar days from either the beginning of the annual reporting period or any change, as identified above.

3.1.4 Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance

Contractor must maintain policies and procedures approved by DHCS to ensure that Network Providers, Subcontractors, and Downstream Subcontractors fully comply with all applicable terms and conditions of this Contract and all duties delegated to Subcontractors and Downstream Subcontractors as set forth above. Contractor must evaluate each prospective Network Provider's, Subcontractor's, and Downstream Subcontractor's ability to perform the contracted services or functions, must oversee and remain responsible and accountable for any services or functions undertaken by a Network Provider, Subcontractor, or Downstream Subcontractor, and must meet all applicable requirements set forth in State and federal law, regulation, any APLs or DHCS guidance, and this Contract.

3.1.5 Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements

A. Network Provider Agreement Requirements

Network Provider Agreements must contain the following provisions:

1) Specification of the Covered Services to be ordered, referred, or rendered;

2) The term of the agreement, including the beginning and ending dates as well as methods of extension, renegotiation, phaseout, and termination, if any;

Back to Agenda Back to Item

3) Full disclosure of the method and amount of compensation or other consideration to be received by Network Provider;

4) Specification that the agreement will be governed by and construed in accordance with all applicable laws and regulations governing the Contract, including but not limited to, Knox-Keene Health Care Service Plan Act of 1975 (KKA), Health and Safety Code (H&S) section 1340 *et seq*. (unless excluded under this Contract); Welfare and Institutions Code (W&I) sections 14000 and 14200 *et seq.*; 28 California Code of Regulations (CCR) section 1300.43 *et seq.*; and 22 CCR sections 53800 *et seq.*, 22 CCR sections 53900 *et seq*;

5) Network Provider will comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, including but not limited to, all applicable federal and State Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, APLs, and provisions of this Contract;

6) Network Provider will submit to Contractor, either directly or through a Subcontractor or Downstream Subcontractor as applicable, complete, accurate, reasonable, and timely Encounter Data and Provider Data, and any other reports or data as requested by Contractor, in order for Contractor to meet its data reporting requirements to DHCS;

7) Network Provider will maintain and make available to DHCS, upon request, copies of all contracts it enters into related to ordering, referring, or rendering Covered Services under the Network Provider Agreement, and will ensure that all such contracts are in writing;

8) Network Provider will make all of its premises, facilities, equipment, books, records, contracts, and computer and other electronic systems pertaining to the Covered Services ordered, referred, or rendered under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Section 1.22 (*Inspection and Audit of Records and Facilities*), as follows:

   a) In accordance with inspections and audits, as directed by DHCS, The Centers for Medicare & Medicaid Services

Back to Agenda Back to Item

(CMS), U.S. Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), the Department of Managed Health Care (DMHC), or their designees; and

b) At all reasonable times at Network Provider's place of business or at such other mutually agreeable location in California.

9) Network Provider will maintain all of its books and records, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term annual of at least ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later;

10) Network Provider will timely gather, preserve and provide to DHCS, CMS, the Division of Medi-Cal Fraud and Elder Abuse (DMFEA), and any authorized State or federal regulatory agencies, any records in Network Provider's possession, in accordance with Exhibit E, Section 1.27 (*Litigation Support*);

11) Network Provider will assist Contractor, or if applicable a Subcontractor or Downstream Subcontractor, in the transfer of Member's care in accordance with Exhibit E, Section 1.17 (*Phaseout Requirements*) in the event of Contract termination, or in the event of termination of the Network Provider Agreement for any reason;

12) Network Providers will be terminated, or subject to other actions, fines, and/or penalties, if DHCS or Contractor determine that the Network Provider has not performed satisfactorily;

13) Network Provider will hold harmless both the State and Members in the event Contractor or, if applicable a Subcontractor or Downstream Subcontractor, cannot or will not pay for Covered Services ordered, referred, or rendered by Network Provider pursuant to the Network Provider Agreement;

14) Network Provider will not bill a Member for Medi-Cal Covered Services;

15) Contractor must inform Network Provider of prospective requirements added by State or federal law or DHCS related to this

Back to Agenda Back to Item

Contract that impact obligations undertaken through the Network Provider Agreement before the requirement would be effective, and agreement by Network Provider to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

16) Network Provider must ensure that cultural competency/humility, sensitivity, Health Equity, and diversity training is provided for employees and staff at key points of contact with Members in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*);

17) Network Provider must provide interpreter services for Members and comply with language assistance standards developed pursuant to H&S section 1367.04;

18) Network Provider must notify Contractor, and Contractor's Subcontractor or Downstream Subcontractor, within ten Working Days of any suspected Fraud, Waste, or Abuse and a provision that allows Contractor to share such information with DHCS in accordance with Exhibit A, Attachment III, Subsection 1.3.2.D (*Contractor's Reporting Obligations*) and Subsection 1.3.2.D.6 (*Confidentiality*);

19) Network Provider must report to Contractor, or Contractor's Subcontractor or Downstream Subcontractor, when it has received an overpayment; return the overpayment to Contractor, or Contractor's Subcontractor or Downstream Subcontractor, within 60 calendar days of the date the overpayment was identified; and notify Contractor, or Contractor's Subcontractor or Downstream Subcontractor, in writing of the reason for the overpayment in accordance with Exhibit A, Attachment III, Subsection 1.3.6 (*Treatment of Overpayment Recoveries*) and 42 Code of Federal Regulations (CFR) section 438.608(d)(2);

20) Confirmation of Network Provider's right to all protections afforded them under the Health Care Providers' Bill of Rights, including, but not limited to Network Provider's right to access Contractor's dispute resolution mechanism and submit a Grievance pursuant to H&S section 1367(h)(1).

21) Network Provider must execute the California Health and Human Services Data Exchange Framework data sharing agreement pursuant to H&S section 130290.

B. Subcontractor and Downstream Subcontractor Agreement Requirements

Subcontractor Agreements and Downstream Subcontractor Agreements must contain the following provisions, as applicable to the specific obligations and functions that Contractor delegates in the Subcontractor Agreement or that the Subcontractor or Downstream Subcontractor delegates in the Downstream Subcontractor Agreement:

1) Specification of Contractor's obligations and functions undertaken by the Subcontractor or Downstream Subcontractor;

2) The term of the Subcontractor Agreement or Downstream Subcontractor Agreement, including the beginning and ending dates as well as methods of extension, renegotiation, phaseout, and termination, if any;

3) Full disclosure of the method and amount of compensation or other consideration to be received by Subcontractor or Downstream Subcontractor per unit of service;

4) Specification that the Subcontractor Agreement or Downstream Subcontractor Agreement and amendments as set forth in this Exhibit A, Subsection 3.1.2 (*DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*);

5) Subcontractor's assignment or delegation of an obligation or responsibility under a Subcontractor Agreement to any Downstream Subcontractor is void unless prior written approval is obtained from DHCS;

6) Downstream Subcontractor's assignment or delegation of an obligation or responsibility under a Downstream Subcontractor Agreement to any Downstream Subcontractor is void unless prior written approval is obtained from DHCS;

7) Specification that the Subcontractor Agreement or Downstream Subcontractor Agreement is governed by and construed in accordance with all applicable laws and regulations governing the Contract, including but not limited to 42 CFR section 438.230; KKA, H&S section 1340 *et seq*. (unless otherwise excluded under this Contract); 28 CFR section 1300.43 *et seq.*; W&I sections 14000

and 14200 *et seq.*; and 22 CCR sections 53800 *et seq.*, 22 CCR sections 53900 *et seq*;

8) Subcontractor and Downstream Subcontractors must comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, pertaining to the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, including but not limited to, all applicable federal and State Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, APLs, and the provisions of this Contract;

9) Language comparable to Exhibit A, Attachment III, Subsection 3.3.16 (*Emergency Services and Post-Stabilization Care Services*), for those Subcontractors or Downstream Subcontractors obligated to reimburse Providers of Emergency Services;

10) Subcontractor and Downstream Subcontractors must submit to Contractor, either directly or through a Subcontractor or Downstream Subcontractor as applicable, complete, accurate, reasonable, and timely Encounter Data and Provider Data, and any other reports and data as requested by Contractor, in order for Contractor to meet its reporting requirements to DHCS;

11) Subcontractor and Downstream Subcontractors must comply with all monitoring provisions of this Contract and any monitoring requests by DHCS;

12) Subcontractor and Downstream Subcontractors must maintain and make available to DHCS, upon request, copies of all contracts it enters into related to the performance of the obligations and functions it undertakes pursuant to the Subcontractor Agreement, and to ensure that such contracts are in writing;

13) Subcontractor and Downstream Subcontractors must make all of their premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Section 1.22 (*Inspection and Audit of Records and Facilities*), as follows:

a) In accordance with inspections and audits, as directed by DHCS, CMS, U.S. DHHS Inspector General, the Comptroller General, DOJ, DMHC, or their designees; and

b) At all reasonable times at Subcontractor's or Downstream Subcontractor's place of business or at such other mutually agreeable location in California.

14) Subcontractor and Downstream Subcontractors must maintain all of its books and records, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term of at least ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later;

15) Subcontractor and Downstream Subcontractors must timely gather, preserve, and provide to DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies, any records in Subcontractor's possession, in accordance with Exhibit E, Section 1.27 (*Litigation Support*);

16) Subcontractor and Downstream Subcontractors must assist Contractor as applicable in the transfer of the Member's care as needed, and in accordance with Exhibit E, Section 1.17 (*Phaseout Requirements*), in the event of Contract termination, or in the event of termination of the Subcontractor Agreement or Downstream Subcontractor Agreement for any reason;

17) Subcontractor and Downstream Subcontractors must notify DHCS in the event the Subcontractor Agreement or any Downstream Subcontractor Agreement is amended or terminated for any reason;

18) Subcontractor and Downstream Subcontractors must hold harmless both the State and Members in the event Contractor, or another Subcontractor or Downstream Subcontractor as applicable, cannot or will not pay for the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement;

19) Subcontractor and Downstream Subcontractors must participate and cooperate in Contractor's Quality Improvement System as applicable;

20) If Subcontractor or Downstream Subcontractors takes on Quality Improvement activities, the Subcontractor Agreement or Downstream Subcontractor Agreement must include those provisions stipulated in Exhibit A, Attachment III, Subsection 2.2.5 (*Subcontractor and Downstream Subcontractor Quality Improvement Activities*);

21) To the extent Subcontractor or Downstream Subcontractor undertakes coordination of care obligations and functions for Members, an agreement to share with Subcontractor and Downstream Subcontractor any utilization data that DHCS has provided to Contractor, and agreement by the Subcontractor and Downstream Subcontractors to receive the utilization data provided and use it solely for the purpose of Member Care Coordination;

22) Contractor must inform Subcontractor of prospective requirements added by federal or State law or DHCS related to this Contract that impact obligations and functions undertaken pursuant to the Subcontractor Agreement before the requirement is effective, and Subcontractor's agreement to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

23) Subcontractor or Downstream Subcontractors must inform the Downstream Subcontractor taking on delegated functions of prospective requirements added by federal or State law or DHCS related to this Contract that impact obligations and functions undertaken pursuant to the Downstream Subcontractor Agreement before the requirement is effective, and the agreement of the Downstream Subcontractor taking on delegated functions to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

24) Subcontractor and Downstream Subcontractors must ensure that cultural competency/humility, sensitivity, Health Equity, and diversity training is provided for Subcontractor's and Downstream Subcontractor's staff at key points of contact with Members in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*);

25) Subcontractor and Downstream Subcontractors must provide interpreter services for Members and comply with language assistance standards developed pursuant to H&S section 1367.04;

26) Subcontractor and Downstream Subcontractors must notify Contractor within ten Working Days of any suspected Fraud, Waste, or Abuse and a provision that allows Contractor to share such information with DHCS in accordance with Exhibit A, Attachment III, Subsection 1.3.2.D (*Contractor's Reporting Obligations*) and Subsection 1.3.2.D.6) (*Confidentiality*);

27) Subcontractor and Downstream Subcontractors must report directly to Contractor, or through the Subcontractor or Downstream Subcontractor, as applicable, when it has received an overpayment; return the overpayment to Contractor within 60 calendar days after the date the overpayment was identified; and notify Contractor in writing of the reason for the overpayment in accordance with Exhibit A, Attachment III, Subsection 1.3.6 *(Treatment of Overpayment Recoveries) and* 42 CFR section 438.608(d)(2);

28) Subcontractor and Downstream Subcontractors must perform the obligations and functions of Contractor undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, including but not limited to reporting responsibilities, in compliance with Contractor's obligations under this Contract in accordance with 42 CFR section 438.230(c)(1)(ii); and

29) Express agreement and acknowledgement by Subcontractor and Downstream Subcontractors that DHCS is a direct beneficiary of the Subcontractor Agreement or Downstream Subcontractor Agreement with respect to all obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, and that DHCS may directly enforce any and all provisions of the Subcontractor Agreement or Downstream Subcontractor Agreement.

30) Subcontractors and Downstream Subcontractors must execute the California Health and Human Services Data Exchange Framework data sharing agreement, if applicable, pursuant to H&S section 130290.

31) Specification of Subcontractors', including Downstream Subcontractors', MLR reporting and remittance obligations pursuant to 42 CFR sections 438.8 and 438.230(c) and Paragraph 11 of the 1915(b) CalAIM SpecialTerms and Conditions (STCs), which include, but are not limited to, the requirements in:

a) Exhibit A, Attachment III, Subsection 1.2.5.A.2 (*Medical Loss Ratio*) for the CalAIM 1915(b) STC downstream requirements and four-part test;

b) Exhibit A, Attachment III, Subsection 1.2.5.B (*Medical Loss Ratio*) for the MLR Experience Defined;

c) Exhibit A, Attachment III, Subsections 1.2.5. C and D (*Medical Loss Ratio*) for the Materiality Threshold;

d) Exhibit A, Attachment III, Subsection 1.2.5. E (*Medical Loss Ratio*) for the MLR numerator and incurred claims for Subcontractors and Downstream Subcontractors;

e) Exhibit A, Attachment III, Subsection 1.2.5.E.1.b.iii (*Medical Loss Ratio*) for remittances received by Subcontractors and Downstream Subcontractors must be deducted from incurred claims;

f) Exhibit A, Attachment III, Subsection 1.2.5.E.1.e.iii (*Medical Loss Ratio*) for remittances paid by Subcontractors and Downstream Subcontractors must be excluded from incurred claims;

g) Exhibit A, Attachment III, Subsection 1.2.5.F (*Medical Loss Ratio*) for MLR denominator;

h) Exhibit A, Attachment III, Subsection 1.2.5.G (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor allocation of expenses;

i) Exhibit A, Attachment III, Subsection 1.2.5.H (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor credibility adjustments;

j) Exhibit A, Attachment III, Subsection 1.2.5.I (*Medical Loss Ratio*) for materiality threshold;

k) Exhibit A, Attachment III, Subsection 1.2.5.J (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor MLR reporting at Subcontractor or Downstream Subcontractor arrangement level by county or rating region;

l) Exhibit A, Attachment III, Subsection 1.2.5.K (*Medical Loss Ratio*) for general MLR reporting requirement imposed on Subcontractors and Downstream Subcontractors;

m) Exhibit A, Attachment III, Subsection 1.2.5.K.4 (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor reporting requirements on downstream entities that accept financial risk;

n) Exhibit A, Attachment III, Subsection 1.2.5.K.5 (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor MLR submission accuracy attestation;

o) Exhibit A, Attachment III, Subsection 1.2.5.K.6 (*Medical Loss Ratio*) for requirements for Subcontractor and Downstream MLR submissions and oversight requirements;

p) Exhibit A, Attachment III, Subsection 1.2.5.M (*Medical Loss Ratio*) for newer experience exemptions for Subcontractors and Downstream Subcontractors;

q) Exhibit A, Attachment III, Subsection 1.2.5.O (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor re-reporting requirements following a retroactive change to the Capitation Payments for a MLR reporting year;

r) Exhibit A, Attachment III, Subsection 1.2.5.P (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor remittance requirements; and

s) Exhibit A, Attachment III, Subsection 1.2.5.Q (*Medical Loss Ratio*) for Subcontractor and Downstream Subcontractor audit and record retention requirements.

3.1.6 Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers

Contractor must maintain a system to evaluate and monitor the financial viability of all Network Providers, Subcontractors, and Downstream Subcontractors that accept financial risk for the provision of Covered Services including, but not limited to, Medi-Cal managed care plans, independent Physician/Provider associations, medical groups, hospitals, risk-bearing organizations as defined by 28 CCR section 1300.75.4(b), Federal Qualified Health Centers (FQHC), and other clinics.

3.1.7 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Federally Qualified Health Centers and Rural Health Clinics

Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with FQHCs, Rural Health Clinics (RHCs), and other clinics must meet the requirements of Exhibit A, Attachment III, Subsections 3.1.5.A and B (*Network Provider Agreement Requirements* and *Subcontractor and Downstream Subcontractor Agreement Requirements*), above, and the reimbursement requirements set forth in Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider)*. Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements with FQHCs, RHCs, and other clinics also must contain a provision stating that any negotiated and agreed-upon rate with an FQHC, RHC, or other clinic constitutes complete reimbursement and payment in full for the Covered Services rendered to a Member.

3.1.8 Network Provider Agreements with Safety-Net Providers

A. Except as provided in subdivisions (1), (2), or (3), Contractor must offer a Network Provider Agreement to, and maintain a Network Provider Agreement with, any Safety-Net Provider physically located and operating within Contractor's contracted geographic service areas if the Safety-Net Provider agrees to provide its applicable scope of services under the same terms and conditions that Contractor requires of other similar Providers.

1) If a Safety-Net Provider is no longer willing to accept a Network Provider Agreement on the same terms and conditions required of other similar Providers, and Contractor elects to terminate or not renew the Network Provider Agreement as a result, Contractor must notify DHCS of its intent to terminate or not renew that Network Provider Agreement with the applicable Safety-Net Provider at least 60 calendar days prior to the effective date of the intended Network Provider Agreement termination or non-renewal.

2) If Contractor determines that the Safety-Net Provider has engaged in Fraud, Waste, or Abuse of the Medi-Cal program; that there are quality of care concerns relating to the Safety-Net Provider's services; or that the Safety-Net Provider has materially breached its Network Provider Agreement, and Contractor elects to terminate or not renew the Network Provider Agreement as a result, Contractor must notify DHCS of its intent to terminate or not renew that

Network Provider Agreement with the applicable Safety-Net Provider at least 60 calendar days prior to the effective date of the intended Network Provider Agreement termination or non-renewal.

3) If DHCS or Contractor determines that the health or welfare of a Medi-Cal Member is threatened by the Provider, Contractor may terminate or not renew the Network Provider Agreement with the applicable Safety-Net Provider immediately, but Contractor must notify DHCS and the Safety-Net Provider of the termination or non-renewal concurrently.

4) If the license of the Safety-Net Provider is revoked or suspended, Contractor must terminate the Network Provider Agreement with the applicable Safety-Net Provider immediately upon discovery of such revocation or suspension, but Contractor must notify DHCS and the Safety-Net Provider of the termination concurrently.

3.1.9 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments

A. Contractor must negotiate in good faith and execute Network Provider Agreements and Subcontractor Agreements, as appropriate, with the Local Health Department (LHD) in each county within Contractor's Service Area for the following public health services:

1) Family Planning Services, as specified in Exhibit A, Attachment III, Subsection 3.3.9 (*Non-Contracting Family Planning Providers*);

2) Sexually Transmitted Disease (STD) services, as specified in Exhibit A, Attachment III, Subsection 3.3.10 (*Sexually Transmitted Disease*), including diagnosis and treatment of the following: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum, and granuloma inguinal;

3) Human Immunodeficiency Virus (HIV) testing and counseling as specified in Exhibit A, Attachment III, Subsection 3.3.11 (*Human Immunodeficiency Virus Testing and Counseling*); and

4) Immunizations as specified in Exhibit A, Attachment III, Subsection 3.3.12 (*Immunizations*).

B. Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with LHDs must specify the

scope and responsibilities of both parties in the provision of services to Members, billing and reimbursements, reporting responsibilities, and how services are to be coordinated between the LHD and Contractor, including exchange of medical information as necessary. Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements must also meet the requirements described in Exhibit A, Attachment III, Subsection 3.1.5 (*Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*).

3.1.10 Nondiscrimination in Provider Contracts

Contractor must not discriminate against Providers, in connection with the participation, reimbursement, or indemnification of any Provider, who is acting within the scope of practice of their license or certification under applicable State law, solely on the basis of that license or certification. If Contractor declines to include individual or groups of Providers in its Network, it must give the affected Providers written notice of the reason for its decision. Contractor's Provider selection policies must not discriminate against Providers that serve high-risk populations or specialize in conditions requiring costly treatment. Upon request, Contractor must provide to DHCS its selection of Providers chosen to meet the need of Contractor's Members. This section will not be construed to require Contractor to contract with Providers beyond the number necessary to meet the needs of Contractor's Members, preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or preclude Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with Contractor's responsibilities to Members.

3.1.11 Public Records

To the extent DHCS receives Contractor's Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, these agreements and all information received in accordance with these agreements will be public records on file with DHCS, except as specifically exempted in statute. The names of the officers and owners of the Network Provider, Subcontractor or Downstream Subcontractor; stockholders owning more than 5 percent of the stock issued by the Network Provider, Subcontractor or Downstream Subcontractor; and major creditors holding more than 5 percent of the debt of the Network Provider, Subcontractor, or Downstream Subcontractor must be attached to the Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement at the time that agreement is submitted to DHCS.

3.1.12 Requirement to Post

Contractor must post on its website a summary of its delegation model that outlines how it delegates obligations and duties of this Contract to Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

Exhibit A, ATTACHMENT III

3.2 Provider Relations

3.2.1 Exclusivity
3.2.2 Provider Dispute Resolution Mechanism
3.2.3 Out-of-Network Provider Relations
3.2.4 Contractor's Provider Manual
3.2.5 Network Provider Training
3.2.6 Emergency Department Protocols
3.2.7 Prohibited Punitive Action Against the Provider
3.2.8 Submittal of Inpatient Days Information

3.2 Provider Relations

3.2.1 Exclusivity

Contractor must not, by use of any exclusivity provision, clause, agreement, nor in any other way, prohibit any Network Provider from providing services to other persons enrolled in Medi-Cal who are not Contractor's Members.

3.2.2 Provider Dispute Resolution Mechanism

In accordance with Health and Safety Code (H&S) section 1367(h)(1), Contractor must have a fast, fair, and cost-effective Provider Dispute Resolution Mechanism in place for Network Providers and out-of-Network Providers to submit disputes.

A. Contractor must have a formal procedure to accept, acknowledge, and resolve Network Provider and out-of-Network Provider disputes. The Provider Dispute Resolution Mechanism must occur in accordance with the timeframes set forth in H&S sections 1371 and 1371.35 for both Network Providers and out-of-Network Providers. Any Provider of Medi-Cal services may submit a dispute to Contractor regarding:

   1) The authorization or denial of a service;

   2) The processing of a payment or non-payment of a claim by Contractor; or

   3) The timeliness of the reimbursement on an uncontested Clean Claim and any interest Contractor is required to pay on claims reimbursement per APL-23-020.

B. Contractor's Provider Dispute Resolution Mechanism must be set forth in all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements.

C. Contractor must inform all Network Providers, out-of-Network Providers, Subcontractors, and Downstream Subcontractors that provide services to Contractor's Members of its Provider Dispute Resolution Mechanism, regardless of contracting status.

D. Contractor must resolve Network Provider and out-of-Network Provider disputes within the timeframes set forth in H&S section 1371.35 of receipt of the dispute, including supporting documentation.

E. Contractor must submit a Provider Dispute Resolution Mechanism report annually to DHCS which includes information on the number of Providers who utilized the Provider Dispute Resolution Mechanism and a summary of the disposition of those disputes, in accordance with H&S section 1367(h)(3). This report must be delineated by Network Providers and out-of-Network Providers, and by Contractor, Subcontractor, or Downstream Subcontractor.

F. On an annual basis, Contractor must assess the Network Providers and out-of-Network Providers that utilize the Provider Dispute Resolution Mechanism to identify trends and systemic issues. Contractor must submit the results of its annual assessment to DHCS with discussion on how it is addressing trends and systemic issues identified based on the assessment.

3.2.3 Out-of-Network Provider Relations

A. Contractor must develop and maintain protocols for payment of claims to out-of-Network Providers, and for communicating and interacting with out-of-Network Providers regarding services and claims payment.

B. Contractor must provide its clinical protocols and evidence-based practice guidelines governing Prior Authorization, Utilization Management (UM) and Retrospective Review to all out-of-Network Providers providing services to its Members. Contractor must arrange to provide these protocols and guidelines at the time that Contractor enters into an agreement with an out-of-Network Provider or anytime an out-of-Network Provider submits a claim for services provided to Contractor's Members.

3.2.4 Contractor's Provider Manual

Contractor must issue a Provider manual to Network Providers, Subcontractors, and Downstream Subcontractors that includes information regarding Medi-Cal Covered Services and responsibilities for the provision of services including Basic Population Health Management (Basic PHM); Care Coordination for Excluded Services; policies and procedures; quality assurance; improvement and monitoring; clinical protocols governing Prior Authorization and UM; timeliness standards; Credentialing; prohibited claims; statutes; regulations; telephone access; special requirements; data reporting; and the Member Grievance, Appeal, and State Hearing process. Contractor must ensure the most updated Provider manual is available through Provider portals, the internet, or upon request. When updates are made to the Provider manual, Contractor must notify Network Providers, Subcontractors, and Downstream Subcontractors.

Contractor must solicit feedback from Contractor committees including but not limited to the Community Advisory Committee (CAC) and Quality Improvement Committee (QIC), to inform the development of Contractor Provider manual and clarify new and revised policies and procedures contained therein.

Contractor must conduct an annual review of its Provider manual and document that the review has been conducted by the appropriate Contractor committees including the QIC. Contractor must update its Provider manual annually or at any time to ensure that the information reflects current requirements.

Contractor's Provider manual must include and inform Network Providers, Subcontractors, and Downstream Subcontractors of the following Member rights information, as set forth in Exhibit A, Attachment III, Section 5.1 (*Member Services*):

A. Member's right to file Grievances and Appeals, and the requirements and timeframes for filing, including the right to have the Member's Medical Record and to have an Authorized Representative (AR) or Provider appeal on the Member's behalf, with written consent from the Member;

B. Availability of assistance in filing a Grievance, Appeal, or State Hearing;

C. Toll-free numbers to file oral Grievances and Appeals;

D. Member's right to request continuation of benefits during an Appeal or State Hearing;

E. Member's right to a State Hearing, how to obtain a State Hearing, and representation rules at a State Hearing; and

F. Member's right to an Independent Medical Review (IMR), if applicable.

3.2.5 Network Provider Training

Contractor must ensure that all Network Providers receive training regarding the Medi-Cal Managed Care program to ensure they operate in full compliance with the Contract and all applicable federal and State statutes, regulations, All Plan Letters (APLs), and Policy Letters (PLs). Contractor must conduct training for all Network Providers. Contractor must start training within ten Working Days and complete training within 30 Working Days after Contractor places a newly contracted Network Provider on active status. Contractor may conduct Network Provider training online or in-person. Contractor must maintain records of attendance to validate that Network Providers received training on a bi-annual basis.

A. Contractor must ensure that Network Provider training includes education on Covered Services, policies and procedures for clinical protocols governing Prior Authorization and UM, and carved out services including, how to refer to and coordinate care with agencies, programs and third parties with which Contractor has a Memorandum of Understanding (MOU) as required under this Contract.

B. Contractor must conduct ongoing training, at least once every two years, for Network Providers on required preventive healthcare services, including Early Periodic Screening, Diagnosis and Testing (EPSDT) services for Members less than 21 years of age; appropriate medical record documentation; and coding requirements. This must include training on existing Contractor data collection and reporting requirements and Quality Improvement programs to ensure required preventive services are offered and provided. This training also must include, but is not limited to, training on Population Health Management (PHM) program requirements (i.e., care management services) including referrals, health education resources, and Provider and Member incentive programs.

C. Contractor must immediately notify Network Providers when changes to its existing policies and procedures impact Network Providers' provision of Medi-Cal Covered Services to Members and not wait until the next biennial mandatory training.

D. Contractor's training must educate Network Providers on Member access, including compliance with appointment waiting time standards and ensuring telephone, translation, and language access is available for Members during hours of operation. Training must also include education on secure methods for sharing information between Contractor, Network Providers, Subcontractors, Downstream Subcontractors, Members, and other healthcare professionals. This must include training on ensuring Providers have accurate contact information for the Member and all Network Providers involved in the Member's care. Contractor must also provide training on how to refer and coordinate care for Members who need access to Excluded Services.

E. Contractor must ensure that Network Provider biennial mandatory training includes information on all Member rights specified in Exhibit A, Attachment III, Section 5.1 (*Member Services*), and diversity, equity and inclusion training (sensitivity, diversity, communication skills, and cultural competency/humility training) as specified in Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*). This process must also include an educational program for Network

Back to Agenda Back to Item

Providers regarding health needs to include but not be limited to, the Seniors and Persons with Disabilities (SPD) population, Members with chronic conditions, Members with Specialty Mental Health Service (SMHS) needs, Members with Substance Use Disorder (SUD) needs, Members with intellectual and Developmental Disabilities (DDs), and Children and Youth with Special Health Care Needs (CYSHCN). Trainings must include Social Drivers of Health (SDOH) and disparity impacts on Members' health care. Attendance records must be reviewed and maintained by Contractor's Health Equity officer.

F. Trainings must be reviewed by the appropriate Contractor committees, including Contractor's board of director's compliance and oversight committee and QIC, routinely, but not less than biennially, to ensure consistency and accuracy with current requirements and Contractor's policies and procedures.

G. In compliance with 42 Code of Regulations (CFR) section 438.236(b), Contractor must ensure that practice guidelines are based on valid and reliable clinical evidence or a consensus of Providers in that particular field, consider the needs of Contractor's Members, are adopted in consultation with Network Providers, and are reviewed and updated periodically as appropriate. In addition to Network Provider training, Contractor must disseminate their practice guidelines to all affected Providers.

3.2.6 Emergency Department Protocols

Contractor must develop and maintain protocols for communicating and interacting with emergency departments in and out of its Service Area. Contractor's protocols must be distributed to all emergency departments in the Service Area and must include, at a minimum, the following:

A. All information on telephone or other secure methods of communicating with Contractor's triage and advice systems;

B. Contact information for Contractor's designated contact person responsible for coordinating Emergency Services who is available 24 hours a day for the coordination of Emergency Services and Post-Stabilization Care Services;

C. Written referral procedures (including after-hours instruction) that emergency department personnel can provide to Members who present at the emergency department for Non-Emergency services;

Back to Agenda Back to Item

D. Procedures for emergency departments to report Contractor's system and/or protocol failures and Contractor's processes for correcting deficiencies when failures occur;

E. Procedures for the authorization and payment of Medically Necessary Post-Stabilization Care Services consistent with 42 CFR section 438.114, APL 19-008, and APL 23-009;

F. Procedures for screening and referral of Members who meet Enhanced Care Management (ECM) Population of Focus eligibility criteria, especially the Individuals at risk for avoidable hospital or Emergency Department utilization Population of Focus; and

G. Procedures for screening and referral of Members who meet medical necessity eligibility criteria for Community Health Workers CHW services.

3.2.7 Prohibited Punitive Action Against the Provider

Contractor is prohibited from taking punitive action against a Provider who either requests an expedited resolution or supports a Member's Appeal. Further, Contractor may not prohibit, or otherwise restrict, a health care professional acting within their lawful scope of practice, from advising, or advocating on behalf of, a Member about:

A. The Member's health status, medical care, treatment options, or alternative treatment options (including any alternative treatment that may be self-administered), including obtaining any information the Member needs in order to decide among all relevant treatment options;

B. The risks, benefits, and consequences of treatment or non-treatment; or

C. The Member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions.

3.2.8 Submittal of Inpatient Days Information

Contractor must report hospital inpatient days to DHCS as required by Welfare and Institutions Code (W&I) section 14105.985(b)(2). Upon DHCS' written request, Contractor must also provide these reports for the time period and in the form and manner specified in DHCS' request, within 30 calendar days of receipt of the request. Contractor must submit additional reports to DHCS, as requested, for the administration of the Disproportionate Share Hospital program.

Exhibit A, ATTACHMENT III

3.3 Provider Compensation Arrangements

3.3.1 Compensation and Value Based Arrangements
3.3.2 Capitation Arrangements
3.3.3 Provider Financial Incentive Program Payments
3.3.4 Identification of Responsible Payor
3.3.5 Claims Processing
3.3.6 Prohibited Claims
3.3.7 Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider
3.3.8 Non-Contracting Certified Nurse Midwife, Nurse Practitioner, and Licensed Midwife Providers
3.3.9 Non-Contracting Family Planning Providers
3.3.10 Sexually Transmitted Disease
3.3.11 Human Immunodeficiency Virus Testing and Counseling
3.3.12 Immunizations
3.3.13 Community Based Adult Services
3.3.14 Organ and Bone Marrow Transplants
3.3.15 Long-Term Care Services
3.3.16 Emergency Services and Post-Stabilization Care Services
3.3.17 Provider-Preventable Conditions
3.3.18 Prohibition Against Payment to Excluded Providers
3.3.19 Compliance with Directed Payment Initiatives and Related Reimbursement Requirements

3.3 Provider Compensation Arrangements

3.3.1 Compensation and Value Based Arrangements

A. Except as otherwise specified in this Contract, Contractor may compensate Providers as Contractor and Provider negotiate and agree.

B. DHCS encourages Contractor to utilize value-based and alternative payment models to compensate Network Providers, especially for Primary Care Covered Services, in ways that ensure Provider accountability for both quality and total cost of care with a focus on population health management. Contractor must monitor and must report, within 90 calendar days of DHCS' request, the number or amount, and percent, of Contractor's Members, Network Providers, and medical expenditures that are made under such payment models, separately for hospital services, professional services, and other services at a minimum.

C. Payment to support Networks based on value: To continue to build and strengthen Networks based on value, Contractors must support their Providers through value-based payment models that promote high-quality, affordable, and equitable care.

On an annual basis, as specified by DHCS, Contractor must report on its Network payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) framework categories as outlined.

D. Effective Primary Care: Contractor must support effective Primary Care and integrated care through use of alternative payment models, such as population-based payment and shared savings. Specifically, Contractor must:

1) Ensure investment in Primary Care service delivery

a) Contractor must report on total Primary Care spend, as defined by the Integrated Healthcare Association (IHA), and the percent of spend within each HCP LAN APM Framework Category. Contractor must report the percentage of spend within each HCP LAN APM Framework Category as a percentage of its total spend.

b) Contract must stratify the reporting of Primary Care spend (and as a percentage of total spend) by age (Children and

Back to Agenda Back to Item

youth ages zero to 20; adults ages 21+), by race/ethnicity, and as requested by DHCS.

c) Contractor must work with DHCS and other stakeholders to analyze the relationship between the percent of spend for Primary Care services with performance of the overall delivery system. If the evidence shows that rebalancing to increase Primary Care spend improves quality or drives lower total cost of care, DHCS may set a target or floor for Primary Care spend in future requirements, and Contractor will be required to meet these targets for minimum Primary Care spend.

2) Ensure promotion of Primary Care delivery through alternative payment models

a) As specified by DHCS, Contractor must report on its Primary Care payment models using the HCP LAN APM Framework Categories.

b) As specified by DHCS, Contractor must report on an annual basis the number and percent of its contracted Primary Care clinicians paid using each HCP LAN APM Framework Category.

c) A description of Contractor's payment model for its five largest medical groups, as defined by the number of Providers, and how its Primary Care clinicians are paid. Contractor must adopt and progressively expand the percent of Primary Care clinicians paid through the HCP LAN APM Framework Categories of population-based payment (Category 4) and alternative payment models built on a fee-for-service structure such as shared savings (Category 3).

3.3.2 Capitation Arrangements

Payments by Contractor to a Network Provider on a capitation basis must be payable effective the date the Member's Enrollment is assigned to the Network Provider. Capitation Payments by Contractor to a Network Provider must be payable no later than 30 calendar days after the Member Assignment.

3.3.3 Provider Financial Incentive Program Payments

A. Contractor may compensate Providers through financial incentive program payments, so long as:

1) Financial incentive program payments to Providers are not designed to induce Providers to reduce or limit Medically Necessary Covered Services provided to a Member;

2) Financial incentive program payments comply with the requirements of All Plan Letter (APL) 19-005, where applicable; and

3) All financial incentive programs related to this Contract are reported in the form, manner, and frequency specified by DHCS.

B. Contractor may implement and maintain a physician incentive plan, as defined in 42 Code of Federal Regulations (CFR) section 422.208, so long as:

1) No specific payment is made directly or indirectly under the physician incentive plan as an inducement to reduce or limit Medically Necessary Covered Services provided to a Member; and

2) The physician incentive plan complies with the requirements of 42 CFR sections 438.3(i) and 438.10(f)(3).

3.3.4 Identification of Responsible Payor

Contractor must provide information to the DHCS fiscal intermediary that identifies the payor(s) responsible for reimbursement of Covered Services provided to a Member. Contractor must identify the Network Provider, Subcontractor, or Downstream Subcontractor responsible for payment, if applicable, and the name and telephone number of the Provider responsible for providing care. Contractor must provide this information upon DHCS' request and in a manner prescribed by DHCS.

3.3.5 Claims Processing

Contractor must pay all Clean Claims submitted by Providers in accordance with this section, unless the Provider and Contractor have agreed in writing to an alternate payment schedule, subject to the following:

A. Contractor must comply with 42 United States Code (USC) section 1396u-2(f) and Health and Safety Code (H&S) sections 1371 - 1371.36 and their implementing regulations. Contractor must be subject to any penalties and

sanctions, including interest at the rate of 15 percent per annum, provided by law if Contractor fails to meet the standards specified in this section.

B. Contractor is expected to pay Clean Claims within 30 calendar days of receipt. For the purpose of establishing compliance thresholds, Contractor must pay at least 90 percent of all Clean Claims from Providers within 30 calendar days of the date of receipt and 99 percent of all Clean Claims within 90 calendar days. For purposes of calculation, the date of receipt is considered the date Contractor receives the claim, as indicated by its date stamp on the claim, and the date of payment is considered be the date of the check or other form of payment. Pursuant to H&S section 1371(a), if Contractor does not pay a Clean Claim within 45 Working Days of receipt, it will owe the Provider interest at the rate of 15 percent per annum beginning on the first day after a 45 Working Day period. For the purposes of calculating interest, the first day is considered to be the first calendar day after 45 Working Days following the receipt of the claim. Contractor must automatically include all accrued interest in any late payment.

C. Contractor must provide direct instruction, training, and technical assistance to its providers to support information transmission and the submission of Clean Claims, including bills or invoices submitted by ECM providers; Community Support providers; Doulas, or other community-based providers that are unable to submit claims through an electronic file format. Contractor must make claiming, billing or invoicing guides and notices readily available to its Providers, including through Provider portals and/or Provider manuals. Contractor is required to train Network Providers to effectively use electronic systems to facilitate timely submission of Clean Claims, equivalent encounters, or bills or invoices.

D. If claims are denied, rejected, or contested in whole or in part, Contractor must specify the reason(s) for contesting or denying a claim and specify the additional information necessary to complete the claim as well as offering technical assistance to remediate deficiencies.

E. Contractor must maintain procedures for pre-payment and post-payment claims review, including review of any data associated with Providers, Members, and the Covered Services for which payment is claimed.

F. Contractor must maintain sufficient claims processing, tracking, and payment systems capability to comply with applicable State and federal law, regulations, and Contract requirements, to determine the status of received claims and to provide an Incurred but Not Reported Claim Estimate as specified by 28 CCR sections 1300.77.1 and 1300.77.2.

3.3.6 Prohibited Claims

A. Contractor must comply with 22 CCR sections 53866, 53220, and 53222 regarding the submission and recovery of claims for services provided under this Contract. Contractor must ensure that its Subcontractors and Downstream Subcontractors also comply with 22 CCR sections 53866, 53220, and 53222.

B. Contractor must hold harmless and indemnify Members for Contractor's debt to Providers for services rendered and billed to Members.

3.3.7 Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider

A. Reimbursement of Non-Contracting Federally Qualified Health Centers (FQHCs) and Rural Health Center (RHCs)

If FQHC and RHC services are not available in Contractor’s Network in a particular county of Contractor’s Service Area, Contractor must reimburse non-contracting FQHCs and RHCs for Covered Services in that county provided to Members at a level and amount of payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a Provider which is not a FQHC or RHC.

B. Required Terms and Conditions for Network Provider Agreements with FQHCs and RHCs

1) Contractor must submit to DHCS, within 30 calendar days of a request and in the form and manner specified by DHCS, documentation of the services provided, the reimbursement level, and amount for each of Contractor’s FQHC and RHC Network Provider Agreements.

2) Contractor must certify in writing to DHCS within 30 calendar days of DHCS’ written request that, pursuant to Welfare and Institutions Code (W&I) sections 14087.325(b) and (d), Contractor’s Network Provider Agreement terms and conditions with FQHCs and RHCs are the same as those offered to other Network Providers providing similar services, and that reimbursement is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a Provider which is not a FQHC or an RHC.

3) Contractor is not required to pay FQHCs and RHCs the Medi-Cal per-visit rate for that clinic.

4) Contractor must fully cooperate with any DHCS review and audit of Contractor's operations and records related to FQHC and RHC reimbursement to ensure compliance with State and federal law.

5) Contractor must submit any FQHC and RHC Network Provider Agreements to DHCS for approval in accordance with W&I section 14087.325.

6) To the extent that an Indian Health Care Provider (IHCP) Facility chooses to participate as an FQHC or RHC, the above requirements in this Paragraph B must apply to a Network Provider Agreement with an IHCP. Moreover, Contractor must pay any non-contracted IHCP that qualifies as an FQHC or RHC an amount equal to what Contractor would pay a contracted FQHC or RHC, and DHCS must make any additional payment needed to comply with 42 CFR section 438.14(c).

7) Contractor or its Subcontractors and Downstream Subcontractors may enter into financial incentive payment arrangements with FQHC and RHC Network Providers provided such agreements meet all applicable conditions of federal and State law and of APL 19-005 including, but not limited to, the following:

   a) Contractor must establish and maintain clear, objective criteria for the financial incentive payments and the conditions under which payments will be made.

   b) The financial incentive payment arrangement must enumerate specific metrics and/or performance terms for the FQHC or RHC to attain the financial incentive payment.

   c) Contractor must have written agreements in place with the FQHC or RHC prior to the start of the financial incentive payment arrangement, including the methodology used to determine the total incentive payment amount.

   d) The financial incentive payments must be similar to, and not less in amount than, other financial incentive payments Contractor makes to non-FQHC or non-RHC Network Providers who are providing similar services.

e) Financial incentive payment arrangements must not result in payments that are less than the payments made by Contractor to non-FQHC or non-RHC Network Providers who are providing similar services.

f) Contractor must evaluate the effectiveness of the financial incentive payments and adjust or discontinue them if they are determined ineffective upon evaluation.

g) Contractor must provide to DHCS, upon request, written agreements for, as well as policies and procedures for oversight and monitoring of, such financial incentive payments.

C. Indian Health Care Providers

1) Contractor must attempt to contract with each IHCP in its Service Area as set forth in 22 CCR sections 55120 - 55180. Contractor must reimburse an IHCP that qualifies as a FQHC but is not a Network Provider as set forth in 42 CFR section 438.14(c)(1).

2) For services provided to Members who are qualified to receive services from an IHCP pursuant to the California Medicaid State Plan, Supplement 6, Attachment 4.19-B, regardless of whether the IHCP is a Network Provider:

a) Contractor must reimburse IHCP at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service (IHS) in accordance with APL 17-020 and APL 21-008.

b) Contractor must ensure compliance with any retroactive changes to the outpatient per-visit rates published in the Federal Register by the IHS by appropriately reimbursing IHCPs in accordance therewith.

c) Contractor must reimburse IHCPs at the Medi-Cal Fee-For-Service (FFS) Rate for services that, pursuant to the California Medicaid State Plan, Supplement 6, Attachment 4.19-B, are not eligible for the outpatient per-visit rate published in the Federal Register by the IHS.

3.3.8 Non-Contracting Certified Nurse Midwife, Nurse Practitioner, and Licensed Midwife Providers

In accordance with 22 CCR section 51345 *et seq*. and APL 18-022, if there are no non-contracting Certified Nurse Midwife (CNM), Nurse Practitioner (NP), or Licensed Midwife (LM) Providers in Contractor's Network, Contractor must reimburse non-contracting CNMs, NPs, or LMs for services provided to Members at no less than the applicable Medi-Cal FFS Rates. For hospitals, the requirements of Exhibit A, Attachment III, Subsection 3.3.16.A.3 (*Emergency Services*), if applicable, apply. For Free Standing Birthing Centers, Contractor must reimburse non-contracting Free Standing Birthing Centers at no less than the applicable Medi-Cal FFS Rate. If an appropriately licensed non-contracting Free Standing Birthing Center is used, Contractor also must pay the Center's facility fee.

3.3.9 Non-Contracting Family Planning Providers

Pursuant to federal law, including but not limited to 42 USC sections 1396a(a)(23) and 1396n(b) and 42 CFR section 431.51, Contractor must reimburse non-contracting family planning Providers at no less than the appropriate Medi-Cal FFS Rate, for services listed in Exhibit A, Attachment III, Subsection 5.2.8 (*Specific Requirements for Access to Programs and Covered Services*), provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

3.3.10 Sexually Transmitted Disease

Pursuant to federal law, including but not limited to 42 USC sections 1396a(a)(23) and 1396n(b) and 42 CFR section 431.51, Contractor must reimburse non-contracted family planning Providers, including local health departments, at no less than the Medi-Cal FFS Rate for the diagnosis and treatment of a Sexually Transmitted Disease (STD) episode, as defined in Policy Letter (PL) 96-09. Contractor must provide reimbursement only if the STD treatment Provider provides treatment records or documentation of the Member's refusal to release Medical Records to Contractor along with billing information.

3.3.11 Human Immunodeficiency Virus Testing and Counseling

Pursuant to federal law, including but not limited to 42 USC sections 1396a(a)(23) and 1396n(b) and 42 CFR section 431.51, Contractor must reimburse non-contracting family planning Providers, including local health departments, at no less than the Medi-Cal FFS Rate for Human Immunodeficiency Virus (HIV) testing and counseling in accordance with PL 97-08. Contractor must provide reimbursement only if such non-contracting family planning Providers make reasonable efforts to report confidential test results to

Contractor in accordance with applicable laws and regulations, including but not limited to H&S section 121025 *et seq*.

3.3.12 Immunizations

Contractor must reimburse local health departments for the administration fee for immunizations given to Members, in accordance with the terms set forth in APL 18-004, who are not already immunized as of the date of the immunization. The local health department must provide immunization records when immunization services are billed to Contractor. Other than local health departments, Contractor is not obligated to reimburse Providers for immunizations under this provision unless the Provider enters into an agreement with Contractor.

3.3.13 Community Based Adult Services

Contractor must reimburse Network Providers for Community Based Adult Services (CBAS) pursuant to a reimbursement structure that must include an all-inclusive per-Member, per-day of attendance rate, or otherwise be reflective of the acuity and/or level of care of the Member population served by Network Providers of CBAS. In accordance with W&I section 14184.201(d)(4), Contractor must reimburse Network Providers of CBAS the amount the Provider could collect if the Member accessed those services in the FFS delivery system, as defined by DHCS in the California Medicaid State Plan and other applicable guidance, including but not limited to guidance issued pursuant to W&I section 14184.102(d), unless Contractor and the Network Provider mutually agree to reimbursement in a different amount. Contractor may include incentive payment adjustments and performance and/or quality standards in its rate structure in paying Network Providers of CBAS.

3.3.14 Organ and Bone Marrow Transplants

In accordance with W&I section 14184.201(d), and for applicable dates of service, Contractor must reimburse a Provider furnishing organ or bone marrow transplant surgeries to a Member the amount the Provider could collect for those same services if the Member accessed those services in the FFS delivery system, as defined by DHCS in the California Medicaid State Plan, a Directed Payment Initiative, and other applicable guidance, including but not limited to guidance issued pursuant to W&I section 14184.102(d).

3.3.15 Long-Term Care Services

In accordance with W&I sections 14184.201(b) and (c), and for applicable dates of service, Contractor must reimburse a Network Provider furnishing institutional Long-Term Care LTC services to a Member the amount the Provider could

collect if the Member accessed those services in the FFS delivery system, as defined by DHCS in the California Medicaid State Plan, a Directed Payment Initiative, and other applicable guidance, including but not limited to guidance issued pursuant to W&I section 14184.102(d). As used in this provision, "institutional LTC services" has the same meaning as set forth in the California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions and, subject to W&I section 141814.201(g), includes, at a minimum, all of the following services: Skilled Nursing Facility (SNF) services; subacute facility services; pediatric subacute facility services; and Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N) services.

3.3.16 Emergency Services and Post-Stabilization Care Services

A. Emergency Services

1) Subject to 42 CFR section 422.113(b), Contractor is responsible for coverage and payment of Emergency Services and must cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with Contractor. Contractor must not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR section 438.114(a)(i) – (iii). Further, Contractor must not deny payment for treatment obtained when a representative of Contractor instructs the Member to seek Emergency Services. Emergency Services must not be subject to Prior Authorization by Contractor.

2) Contractor must not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms or refuse to reimburse Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's Primary Care Providers, Contractor, or DHCS of the Member's screening and treatment for Emergency Services. A Member who has an Emergency Medical Condition must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.

3) Contractor must reimburse Providers for Emergency Services received by a Member from out-of-Network Providers. Payments to non-contracting Providers must be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's

condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge. The treating Provider is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on Contractor. Emergency Services must not be subject to Prior Authorization by Contractor.

4) At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated Providers for physician services at the lowest level of the emergency department evaluation and management physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

5) For all non-contracted Emergency Services Providers, reimbursement by Contractor or by a Subcontractor or Downstream Subcontractor who is at risk for out-of-Network Emergency Services for properly documented claims for services rendered by out-of-Network Provider pursuant to this provision must be made in accordance with Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*) above and 42 USC section 1396u-2(b)(2)(D).

B. Post-Stabilization Care Services

1) Except for the response time periods set forth in 42 CFR section 422.113(c)(2)(ii) and (iii)(A), Post-Stabilization Care Services must be covered by and paid for in accordance with 42 CFR section 422.113(c) and APL 23-009. Applicable response time periods involving Post-Stabilization Care Services is governed by Exhibit A, Attachment III, Subsection 2.3.2(B) (*Timeframes for Medical Authorization*) of this Contract and APL 23-009. Contractor is financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's Network that are authorized by Contractor, Subcontractor, or Downstream Subcontractor.

2) In accordance with 28 CCR section 1300.71.4, Contractor must approve or disapprove a request for Post-Stabilization Care Services made by a Provider on behalf of a Member within 30 minutes of the request. If Contractor fails to approve or disapprove authorization within the required timeframe, the authorization is deemed approved.

3) Contractor is also financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's Network that are not authorized by Contractor, Subcontractor, or Downstream Subcontractor, but administered to maintain, improve, or resolve the Member's stabilized condition if Contractor, Subcontractor, or Downstream Subcontractor does not respond to a request for authorization within 30 minutes; Contractor, Subcontractor, or Downstream Subcontractor cannot be contacted; or Contractor, Subcontractor, or Downstream Subcontractor and the treating Provider cannot reach an agreement concerning the Member's care. In this situation, the treating Provider may continue with care of the Member until Contractor, Subcontractor, or Downstream Subcontractor is reached and assumes responsibility for the Member's care or one of the criteria of 42 CFR section 422.113(c)(3) is satisfied.

4) Contractor's financial responsibility for Post-Stabilization Care Services it has not authorized ends when a Network Provider with privileges at the treating hospital assumes responsibility for the Member's care; a Network Provider assumes responsibility for the Member's care through transfer; Contractor's Representative and the treating Provider reach an agreement concerning the Member's care; or the Member is discharged.

5) Consistent with 42 CFR sections 438.114(e), 422.113(c)(2), and 422.214, Contractor is financially responsible for payment of Post-Stabilization Care Services, following an emergency admission, at the hospital's Medi-Cal FFS Rate for general acute care inpatient services rendered by a non-contracting, Medi-Cal certified hospital, unless a lower rate is agreed to in writing and signed by the hospital.

   a) For the purposes of this Subsection 3.3.16 (*Emergency Services and Post-Stabilization Care Services*), the FFS payment amounts for dates of service when the Post-Stabilization Care Services were rendered must be the FFS payment method known as diagnosis-related groups, which for the purposes of this Paragraph 5 must apply to all acute care hospitals, including public hospitals that are reimbursed under the certified public expenditure basis methodology (W&I section 14166 *et seq.*), less any associated direct or indirect medical education payments to the extent applicable.

b) Payment made by Contractor to a hospital that accurately reflects the payment amounts required by this Paragraph 5 must constitute payment in full and must not be subject to subsequent adjustments or reconciliations by Contractor, except as provided by Medicaid law and regulations. A hospital's tentative and final cost settlement processes required by 22 CCR section 51536 must not have any effect on payments made by Contractor pursuant to this Paragraph 5.

C. Disputed claims involving Emergency Services and/or Post-Stabilization Care Services may be submitted for resolution under provisions of W&I section 14454 and 22 CCR section 53620 *et seq.* (except section 53698) to:

Department of Health Care Services
Office of Administrative Hearings and Appeals
3831 North Freeway Blvd, Suite 200
Sacramento, CA 95834

Contractor agrees to implement DHCS' determination and reimburse the out-of-Network Provider within 30 calendar days of the effective date of a decision that Contractor is liable for payment of a claim and must provide proof of reimbursement in such form as DHCS directs. Failure to reimburse the out-of-Network Provider within 30 calendar days must result in capitation offsets in accordance with W&I sections 14454(c) and 14115.5 and 22 CCR section 53702 and may subject Contractor to sanctions pursuant to W&I section 14197.7.

3.3.17 Provider-Preventable Conditions

Contractor, Subcontractor, or Downstream Subcontractor, or Network Provider must not pay any Provider claims nor reimburse a Provider for a Provider-Preventable Condition (PPC) in accordance with 42 CFR section 438.3(g). Contractor must report and require any and all of its Network Providers, Subcontractors, and Downstream Subcontractors to report PPCs in the form and frequency required by APL 17-009.

3.3.18 Prohibition Against Payment to Excluded Providers

In accordance with 42 USC section 1396b(i)(2), Contractor must not pay any amount for any services or items, other than Emergency Services, to an Excluded Provider as defined in Exhibit A, Attachment III, Subsection 1.3.4.A, (*Tracking Suspended, Excluded, and Ineligible Providers*) of this Contract. This

prohibition applies to non-emergent services furnished by a Provider at the medical direction or prescribed by an Excluded Provider when the Provider knew or had a reason to know of the exclusion or prescribed by an Excluded Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of Fraud.

3.3.19 Compliance with Directed Payment Initiatives and Related Reimbursement Requirements

Contractor must reimburse eligible Providers in accordance with the terms of applicable Pass-Through Payments and Directed Payment Incentives as specified in Exhibit B, Section 1.14 (Special Contract Provisions Related to Payment). Contractor must provide Provider-level data to DHCS and Providers eligible for Directed Payment Initiatives in a form and manner specified by DHCS through APLs or other technical guidance.

Exhibit A, ATTACHMENT III

4.0 Member

DHCS is committed to ensuring that the Medi-Cal Member's experience is at the center of health care delivery from the point of Enrollment into a managed care plan throughout their time as a Member.

This Article makes explicit DHCS' commitment to a comprehensive population health managed approach that ensures all Members have equitable access to necessary wellness and prevention services, Care Coordination, Complex Care Management (CCM), Transitional Care Services, and Enhanced Care Management (ECM). From assessing the needs of Members on a population basis, to identifying and stratifying Members' risk on an individual basis, Contractors are required to have the systems (including data analytic capabilities), processes, and people (including ECM Providers in network with direct experience working with specific Populations of Focus) to support appropriate Population Health Management functions.

This Article also makes explicit DHCS' commitment to ensure that Members are appropriately accessing Covered Services, including when they are referred to community-based Providers. For example, Contractor must ensure referrals to services provided by Community Health Workers (CHWs), peer counselors, and local community organizations providing Community Support services.

This Article includes provisions that directly address Social Drivers of Health (SDOH) – from capturing and tracking SDOH data to providing Community Support services. Community Support services, such as medically tailored meals and short-term post-hospitalization services, are intended to address SDOH and can be provided by Contractors to the extent they are medically appropriate, cost-effective substitutes for Covered Services.

Finally, this Article outlines provisions related to Grievances and Appeals which includes processes by which Contractors must inform Members of their rights and ensure seamless processes by which Members can exercise their rights. DHCS also includes reporting requirements to enable DHCS to effectively monitor, oversee, and enforce Contract provisions when needed.

4.1 Marketing

4.1.1 Training and Certification of Marketing Representatives
4.1.2 Marketing Plan

4.1 Marketing

4.1.1 Training and Certification of Marketing Representatives

Before conducting any Marketing, Contractor must develop a training and certification program for Contractor's Marketing Representatives, and ensure that all staff performing any Marketing activities or distributing Marketing Materials are appropriately certified.

A. Contractor is responsible for all Marketing activities conducted on its behalf. Contractor is liable for all violations committed by any of its Marketing Representatives. Marketing staff must not provide Marketing services for more than one Contractor, and Marketing strategies must align with Contractor's efforts in improving Health Equity. Marketing Representatives must not engage in Marketing practices that illegally discriminate against a Member or Potential Member on the basis of any characteristic protected by federal or State law. Such protected characteristics include, without limitation, sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56. Contractor must ensure all Marketing activities and Marketing Materials are culturally and linguistically competent in compliance with Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*) and Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*).

B. Training Program

Contractor must develop a training program that will train staff and prepare Marketing Representatives for certification. Prior to implementation, Contractor must obtain written approval from DHCS for Contractor's training and certification program, and any changes in the program. Contractor must develop and provide to Marketing Representatives a staff orientation and Marketing Representative training/certification manual. At a minimum, the manual must explain:

1) The Medi-Cal program, including Medi-Cal Fee-For-Service (FFS), Medi-Cal managed care, Network Providers, Subcontractors, Downstream Subcontractors, and program eligibility;

2) The Medi-Cal scope of services;

Back to Agenda Back to Item

3) Contractor's administrative operations and health delivery system program, including the Service Area covered, Excluded Services, additional services, conditions of Member Enrollment, and aid categories;

4) Contractor's Utilization Management policy, including, but not limited to, how Members are obligated to obtain all Non-Emergency medical care through Contractor's Network and a description of all prerequisites to medical care and other health care services, such as referrals and Prior Authorizations;

5) Contractor's Grievance and Appeals procedures; the State Hearing process; and, as applicable to Contractor's plan model, the Independent Medical Review (IMR) process;

6) When Members can disenroll from Contractor, including qualifying conditions for both voluntary and mandatory disenrollment;

7) Contractor's obligation to keep confidential any information obtained from Members and Potential Members, including information regarding eligibility under any public welfare or social services program;

8) How Contractor will supervise and monitor its Marketing Representatives and staff to ensure compliance with applicable statutes and regulations;

9) The types of acceptable and prohibited communication methods and sales techniques Marketing Representatives may or may not use;

10) Contractor's anti-discrimination policy and the prohibition against the Enrollment or failure to enroll a Member or Potential Member due to a pre-existing medical condition (except for conditions requiring Excluded Services); and

11) The consequences of Marketing misrepresentation and Abuse, including, but not limited to, discipline, suspension of Marketing activities, termination, and civil and criminal prosecution. The Marketing Representative and Contractor must understand that any Abuse of Marketing requirements can result in termination of this Contract.

4.1.2 Marketing Plan

Before conducting any Marketing, or implementing any Marketing plan, Contractor must develop and obtain DHCS written approval for its Marketing plan or changes to a Marketing plan as specified below. The Marketing plan must be specific to the Medi-Cal program only and Marketing Materials must be distributed within Contractor's entire Service Area. Contractor must ensure that the Marketing plan and all related materials are accurate and do not mislead, confuse, or defraud Members, Potential Members, or the Medi-Cal program.

A. Contractor must submit a Marketing plan to DHCS for review and approval on an annual basis and any time Contractor desires to change its Marketing plan. The Marketing plan, whether new or revised, must describe all of Contractor's current and proposed Marketing, including, but not limited to, all procedures, activities, events, and methods.

B. Contractor's Marketing plan must contain the following:

1) A table of contents section that divides the Marketing plan into chapters, sections, or pages. Each page must be dated and numbered so that chapters, sections, or pages can be easily identified and replaced when revised.

2) A mission statement or statement of purpose for the Marketing plan.

3) An organizational chart including key staff positions and the Marketing director's name, address, telephone, and facsimile number.

4) A narrative description explaining how Contractor's internal Marketing department operates by identifying key staff positions, roles, and responsibilities. The narrative must also report relationships including, if applicable, how Contractor's commercial Marketing staff and functions interface with Contractor's Medi-Cal Marketing staff and functions.

5) Copies of all Member incentives Contractor will distribute during any Marketing event or through any other Marketing activities, in accordance with All Plan Letter (APL) 16-005.

6) An explicit description of all of Contractor's expected Marketing methods and activities.

7) Documentation of all agreements between Contractor and the organizations with which it is undertaking Marketing activities.

8) All Marketing Materials Contractor will use, including those for English-speaking populations, non-English speaking populations, and alternative formats for people with disabilities (including Braille, large-size print font no smaller than 20-point, accessible electronic format, and audio format).

9) A description of the methods Contractor will use to distribute Marketing Materials in compliance with APLs, this Contract, and State and federal law, including, but not limited to, the Telephone Consumer Protection Act of 1991 (47 United States Code (USC) section 227).

10) Copies of a sample Marketing identification badge and business card clearly identifying Marketing Representatives as Contractor's employees. Marketing identification badges and business cards must not resemble those of a government agency.

11) Written formal procedures for monitoring the performance of Contractor's Marketing Representatives to ensure Marketing integrity, pursuant to Welfare and Institutions Code (W&I) section 14408(c).

12) All sites for proposed Marketing activities, such as annual health fairs and community events in which Contractor proposes to participate.

13) All other information requested by DHCS to assess Contractor's Marketing program.

C. If Contractor wishes to conduct a Marketing activity not included in the approved Marketing plan, Contractor must submit a written request and obtain prior written approval for that Marketing activity from DHCS. Contractor must submit the written request, a copy of the proposed Marketing Materials, and all other required documentation at least 30 calendar days prior to the Marketing activity, unless DHCS agrees to a shorter review period.

D. At least 30 calendar days before Contractor's participation in any proposed Marketing events, Contractor must notify its designated DHCS Contract Manager in writing and provide required documentation for DHCS review and approval. In cases where Contractor learns of a

Marketing event less than 30 calendar days before the event, Contractor must immediately provide written notification and required documentation to DHCS for review and approval. In no instance may notification be less than two Working Days before the Marketing event.

E. At least 30 calendar days before Contractor's participation in any proposed Marketing events, Contractor must submit a community event Marketing agreement for DHCS review and approval. Along with the community event Marketing agreement, there must be an attestation from the event organization stating that:

1) Contractor will not distribute Marketing Materials or conduct Marketing presentations at a Network Provider, Subcontractor, Downstream Subcontractor, or out-of-Network Provider site, including hospitals and their property; and

2) There are trained Marketing staff at the Marketing event and, if the Marketing event is educational, there are trained health educators at the Marketing event.

F. Contractor must obtain prior DHCS approval before performing in-home Marketing presentations and must provide strict accountability, including documentation from the Potential Member requesting an in-home Marketing presentation or a telephone log entry documenting the Potential Member's request.

G. Contractor must submit any advertisement intended for Marketing purposes to DHCS for prior approval. Such advertisements include, but are not limited to, mass media, magazines, newspapers, radio, telephonic Marketing, TV, billboards, bus sides, and any mobile advertisements.

H. Contractor must not position any mobile advertisements at any Network Provider, Subcontractor, Downstream Subcontractor, or non-contracted Provider sites, including hospitals and their property.

I. When conducting Marketing, Contractor must comply with W&I sections 10850(b), 14407.1, 14408, 14409, 14410, and 14411 and 22 California Code of Regulations (CCR) sections 53880 and 53881.

J. Contractor must not engage in door-to-door, telephone, e-mail, texting, or other Cold-Call Marketing for the purpose of enrolling Potential Members, or for any other purpose.

K. Contractor must not distribute Marketing Materials or conduct Marketing presentations at any Network Provider, Subcontractor, Downstream Subcontractor, or out-of-Network Provider sites, including hospitals and their property.

L. Contractor must not seek to influence Enrollment in conjunction with the sale or offering of any private insurance.

M. Contractor's Marketing Materials must not contain any statements that suggest Enrollment is necessary to obtain or to avoid losing Medi-Cal benefits, or that Contractor is endorsed by DHCS, Center for Medicare & Medicaid Services (CMS), or any other State or federal government entity.

N. All of Contractor's Marketing must be accurate and not mislead, confuse, or defraud Members, Potential Members, or the Medi-Cal program, pursuant to 42 Code of Federal Regulations (CFR) section 438.104.

Exhibit A, ATTACHMENT III

4.2 Enrollments and Disenrollments

4.2.1 Enrollment
4.2.2 Disenrollment

4.2 Enrollments and Disenrollments

4.2.1 Enrollment

Contractor must cooperate with the DHCS Enrollment processes and the DHCS Enrollment contractor in enrolling all Potential Members into Medi-Cal managed care health plans. DHCS and its Enrollment contractor will verify eligibility status and notify the Potential Member of the available Medi-Cal managed care health plans in their County. Contractor must ensure mandatory and voluntary Potential Members residing in its Service Area, are properly enrolled pursuant to the requirements of this provision.

A. Non-Discrimination in Enrollment

Contractor must accept as Members all Potential Members who select or are assigned to Contractor without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, pre-existing medical condition(s), genetic information, health status, marital status, gender, gender identity, sexual orientation, existing or prior involvement in the justice system, or identification with any other persons or groups defined in California Penal Code section 422.56.

B. Enrollment Processing Criteria

1) Contractor must accept as Members all Potential Members who meet the Enrollment criteria in 22 California Code of Regulations (CCR) section 53845, as follows:

a) Potential Members with a Mandatory aid code unless they qualify for an exemption from Enrollment pursuant to 22 CCR section 53887 or meet the criteria in 22 CCR section 53891(c).

b) Potential Members with a Mandatory aid code who are default enrolled because they did not select a Medi-Cal managed care plan during the choice timeframe.

c) Potential Members with a Justice Involved aid code who are default enrolled per the Justice Involved Reentry Initiative, as described in the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative.

d) Potential Members with a Voluntary aid code who select Contractor as their Medi-Cal managed care plan.

C. Enrollment Process

1) Contractor will receive an effective Enrollment date from DHCS that is no later than 90 calendar days from the date that Medi-Cal Eligibility Data System (MEDS) lists the individual as meeting the required Enrollment criteria contained in 22 CCR section 53845(a).

2) DHCS or its Enrollment contractor will assign Potential Members meeting the Enrollment criteria contained in 22 CCR section 53845(a) to Medi-Cal Managed Care Health Plans in accordance with 22 CCR section 53884, if the Potential Member fails to select a plan after receiving notice that they are required to enroll in Medi-Cal Managed Care.

3) Notwithstanding any other provision in this Contract, Paragraphs 1) and 2) above do not apply to Potential Members without a current valid deliverable address or with an address designated as a county post office box for homeless Members.

D. Enrollment Disputes

1) Contractor must notify DHCS of Enrollment disputes, pursuant to the requirements and procedures contained in Exhibit E, Section 1.21 (*Contractor's Dispute Resolution Requirements*).

2) DHCS has 120 calendar days from the date of DHCS' receipt of Contractor's Enrollment dispute notice (the "cure period") to make necessary Enrollment corrections or adjustments, identified in Contractor's dispute notice, without incurring any financial liability to Contractor. For purposes of this Provision, DHCS will be deemed to have corrected or adjusted any issues identified in Contractor's notice if, within the cure period, any of the following occurs:

a) Mandatory plan Members receive an effective Member Assignment date that is within the cure period; or

b) DHCS corrects or adjusts an Enrollment issue by redirecting Enrollment from Contractor to another Contractor within the cure period; or

Back to Agenda Back to Item

c) Within the cure period, DHCS changes the distribution of Member Assignment, subject to the requirements of 22 CCR section 53845, to the maximum extent new Members are available to be assigned, to adjust for the number of incorrectly assigned Members.

3) If it is necessary to redirect Enrollment or change the distribution of Member Assignment and such change varies from the requirements of 22 CCR section 53884(b)(5) or (b)(6), Contractor agrees it will neither seek legal nor equitable relief for such variance or the results of such variance if DHCS resumes assignment consistent with 22 CCR sections 53884(b)(5) or (b)(6) after any necessary Enrollment correction or adjustment.

4) DHCS will not be financially liable to Contractor for any Enrollment dispute, in an affected county (on a county-by-county basis) if Contractor's loss of mandatory plan Members, in a month in which a dispute occurs, is less than 5 percent of Contractor's total Members in that affected county. The parties acknowledge that the above referenced 5 percent threshold will apply on a county-by-county basis, not in the aggregate. DHCS' financial liability must not exceed 15 percent of Contractor's monthly Capitation Payment.

E. Coverage

1) Member coverage begins at 12:01 a.m. on the first day of the calendar month for which the Potential Member's name is included on the list of new Members assigned to Contractor. The term of Enrollment continues indefinitely until this Contract expires, is terminated, or the Member is disenrolled pursuant to the conditions described in Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*) below.

2) Contractor must authorize and provide coverage for Medically Necessary Covered Services to a Child born to a Member for the month of birth and the following month. No additional Capitation Payment is owed Contractor for the services provided to the newborn Child for month of birth and the month following birth.

F. Temporary Exemption from Mandatory Enrollment

A Member in a mandatory aid code category who currently has a DHCS approved medical exemption request pursuant to 22 CCR section 53887

will not be assigned to Contractor until the medical exemption expires or the medical exemption is subsequently denied by DHCS.

G. Mandatory Assignment Restrictions

Assignment will continue on a monthly basis unless restricted by DHCS. DHCS will impose assignment restrictions and provide written notice to Contractor at least ten calendar days prior to the start of the restriction period. DHCS will notify Contractor at least ten calendar days before the end of the restriction period.

4.2.2 Disenrollment

DHCS or its agent will process a Member's disenrollment from Contractor under the following conditions, in accordance with the provisions of 22 CCR section 53891:

A. Disenrollment from Contractor is mandatory when:

1) The Member requests disenrollment with a request for Enrollment in the competing Medi-Cal managed care plan pursuant to 22 CCR section 53891(c), subject to any lock in restrictions on disenrollment under the federal lock in option, if applicable, or when the Member enrolls in a Medicare Advantage plan that is affiliated with a competing Medi-Cal managed care plan.

2) The Member is no longer eligible for Enrollment with Contractor because they lost Medi-Cal eligibility, including the death of a Member.

3) Contractor's contract is terminated or Contractor no longer participates in the Medi-Cal Program.

4) Enrollment was in violation of 22 CCR section 53891(a)(2), or requirements of this Contract regarding Marketing.

5) The Member requests disenrollment in accordance with Welfare and Institutions Code (W&I) section 14303.1, following a merger with other organizations, or W&I section 14303.2, following a reorganization or merger, with a parent or subsidiary corporation. In these circumstances, Contractor must give Members the option to disenroll for any cause, and request Enrollment in another Medi-Cal managed care plan within 60 calendar days following the date of

the reorganization or merger. Contractor must not disenroll the Member to Fee-For-Service (FFS).

6) A Member's change of residence is outside of Contractor's Service Area.

Mandatory disenrollment from Contractor will be effective on the first day of the next month after DHCS receives all documentation it determines are necessary to process the disenrollment, provided disenrollment was requested at least 30 calendar days prior to that date.

B. Except as provided in above Paragraph A.6) of this Subsection, Enrollment terminates no later than midnight on the last day of the first calendar month after DHCS receives the Member's disenrollment request and all required supporting documentation for Enrollment in a competing plan. On the first day after Enrollment ceases, Contractor is relieved of all obligations to provide Covered Services to the Member under the terms of this Contract. Contractor agrees in turn to return to DHCS any Capitation Payment forwarded to Contractor for Members no longer enrolled with Contractor under this Contract.

C. Contractor must implement and maintain procedures to ensure that all Members requesting disenrollment are provided an explanation of the Member's right to disenroll at any time, with the requirement that the Member enroll in the competing Medi-Cal managed care plan in the county, subject to the requirements in 22 CCR section 53891(c), and any restricted disenrollment period. Additionally, Contractor must immediately refer Members requesting disenrollment from Contractor to the DHCS Enrollment contractor so the Member may be enrolled in another Medi-Cal managed care plan or disenrolled because they require a carved-out service.

Exhibit A, ATTACHMENT III

4.3 Population Health Management and Coordination of Care

4.3.1 Population Health Management Program Requirements
4.3.2 Population Needs Assessment
4.3.3 Data Integration and Exchange
4.3.4 Medi-Cal Connect (DHCS' PHM Service)
4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering
4.3.6 Screening and Assessments
4.3.7 Care Management Programs
4.3.8 Basic Population Health Management
4.3.9 Other Population Health Requirements for Children
4.3.10 Transitional Care Services
4.3.11 Targeted Case Management Services
4.3.12 Mental Health Services
4.3.13 Alcohol and Substance Use Disorder Treatment Services
4.3.14 California Children's Services
4.3.15 Services for Persons with Developmental Disabilities
4.3.16 School-Based Services
4.3.17 Dental
4.3.18 Direct Observed Therapy for Treatment of Tuberculosis
4.3.19 Women, Infants, and Children Supplemental Nutrition Program
4.3.20 Home and Community-Based Services Programs
4.3.21 In-Home Supportive Services
4.3.22 Indian Health Care Providers
4.3.23 Justice Involved Reentry Coordination
4.3.24 Managed Care Liaisons

4.3 Population Health Management and Coordination of Care

4.3.1 Population Health Management Program Requirements

A. Contractor must develop and maintain a Population Health Management (PHM) program that ensures all Members have equitable access to necessary wellness and prevention services, Care Coordination and care management. Contractor must assessMember needs across the continuum of care based on Member preferences, data-driven risk stratification, identified gaps in care and standardized assessment processes at both the individual Member level, and at the community level. Contractor must maintain a PHM program that seeks to improve the health outcomes of all Members consistent with the requirements set forth in this Section and DHCS guidance. Contractor must report on PHM program operations, effectiveness, and outcomes based on DHCS guidance specified in the PHM Policy Guide, as noted in All Plan Letter (APL) 22-024.

B. Contractor must ensure its PHM program meets, at a minimum, all National Committee for Quality Assurance (NCQA) PHM standards as well as applicable federal and State requirements as set forth in APL 22-024. As described in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*) and in accordance with APL 23-021, Contractor must fulfill its Population Needs Assessment (PNA) requirement by meaningfully participating in the local health jurisdiction (LHJ) Community Health Assessment (CHA)/ Community Health Implementation Plan (CHIP) process in the Service Area county(ies) in which it operates, and submit a PHM Strategy, informed by PNA findings, to DHCS. PHM Strategy submission documentation will include an NCQA-approved PHM strategy for accredited Plans. Contractor that has not yet obtained NCQA accreditation is still responsible for submitting PHM Strategy documentation prepared for near-future NCQA submission in line with NCQA Health Plan Accreditation standards, inclusive of population assessment documentation informing PHM Strategy and accreditation application process if Contractor is without current accreditation, upon DHCS request.

4.3.2 Population Needs Assessment

A. Contractor must conduct a Population Needs Assessment (PNA) by participating in the CHA/CHIP processes led by Local Health Departments (LHDs) in the Service Area county(ies) where Contractor operates, as defined further in APL 23-021 and the PHM Policy Guide.

B. Contractor operating in multiple LHD jurisdictions must participate in the CHA/CHIP process for each jurisdiction in which it operates.

C. Contractor must submit an annual PHM Strategy that demonstrates that Contractor is responding to community needs and provides PHM updates as specified and, in the format prescribed by DHCS.

D. Contractor must ensure that any populations covered by a Fully Delegated Subcontractor, Partially Delegated Subcontractor, or Downstream Subcontractor are included in the PNA and PHM Strategy process.

E. Contractor must publish on its website all LHD CHAs/CHIPs in the Service Area along with a brief description of how Contractor participated in the CHA/CHIP process. Contractor must also share findings from the CHA/CHIPs in Service Area with their Community Advisory Committees (CACs).

F. Based on participation in the CHA/CHIP process in the Service Area, Contractor must annually review and update the following in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy:

1) Targeted health education materials for Members, including Member-facing outreach materials for any identified gaps in services and resources, including but not limited, to Non-Specialty Mental Health Services;

2) Cultural and linguistic and quality improvement strategies to address identified population-level health and social needs; and

3) Wellness and prevention programs.

G. Contractor's MOU with an LHD must include a requirement that Contractor coordinate with the LHD to develop a process to implement DHCS guidance regarding the PNA and PHM Strategy requirements.

H. The PNA and PHM Strategy requirements, as outlined in this Subsection, and other PHM deliverables, as described in this Contract, remain consistent with 22 CCR, sections 53876, 53851(b)(2), 53851(e), 53853(d), and 53910.5(a)(2), 28 CCR, section 1300.67.04; 42 CFR sections 438.206(c)(2), 438.330(b)(4) and 438.242(b)(2); and APL 23-021.

I. Additional operational details on the PNA and PHM Strategy are located in the PHM Policy Guide. Any future updates will also be communicated to Contractor via the PHM Policy Guide.

4.3.3 Data Integration and Exchange

In accordance with the Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access final rule (CMS-9115-F) and applicable federal and State data exchange requirements, Contractor must integrate its PHM data by expanding its Management Information System (MIS) capabilities outlined in Exhibit A, Attachment III, Section 2.1 (*Management Information System*), as follows:

A. Integrate additional data sources in accordance with all NCQA PHM standards to ensure the ability to assess the needs and characteristics of all Members;

B. Enhance interoperability of its MIS to allow for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks as specified by the DHCS;

C. Enhance interoperability of the PHM Service, in support of population health principles, integrated care, and Care Coordination across delivery systems;

D. Provide DHCS with administrative, clinical, and other data requirements as specified by the DHCS; and

E. Comply with all data sharing agreements, including data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with Health & Safety Code (H&S) section 130290.

F. Comply with the CMS Interoperability and Patient Access Final Rule set forth at CMS-9115-F.

4.3.4 Medi-Cal Connect (DHCS' PHM Service)

Contractor must use the PHM Service in accordance with all applicable federal and State laws and regulations, and in a manner specified by DHCS. Contractor must use the PHM Service, at a minimum, to:

A. Perform Risk Stratification and Segmentation (RSS) activities and Risk Tiering functions as described in this Subsection;

B. Identify and assess Member-level risks and needs through use of the PHM Service's Risk Tiering functionality, which places Members into high, medium-rising, or low Risk Tiers, and use the RSS and Risk Tiering functionality to identify and assess Member-level risks and needs as specified in the PHM Policy Guide;

C. Inform and enable Member screening and assessment activities, including pre-populating screening and assessment tools; and

D. Support Member engagement and education activities.

4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering

A. Contractor must use RSS and Risk Tiering to identify and assess Member-level risks and needs and, as needed, connect Members to services in a manner specified in the PHM Policy Guide and detailed below:

1) Consider findings from the PNA and all Members' behavioral, developmental, physical, oral health, and Long-Term Services and Supports (LTSS) needs, as well as health risks, rising-risks, and health-related social needs due to SDOH;

2) Comply with NCQA PHM standards;

3) Risk stratify and/or segment all Members at least annually and during each of the following timeframes:

a) Upon each Member's Enrollment;

b) Annually after each Member's Enrollment;

c) Upon a Significant Change in the health status or level of care of the Member; and

d) Upon the occurrence of events or new information that Contractor determines as potentially changing a Member's needs, including but not limited to, referrals for Complex Care Management (CCM), Enhanced Care Management (ECM), and Transitional Care Services.

4) Submit its processes to DHCS upon request regarding how it identifies Significant Changes in Members' health status or level of care and how it is monitoring appropriate re-stratification;

5) Incorporate a minimum list of data sources, as specified in the PHM Policy Guide;

6) Avoid and reduce biases in its RSS approach, such as only using utilization data, by using evidence-based methods to prevent further exacerbation of Health Disparities; and

7) Continuously reassess the effectiveness of the RSS methodologies and tools.

B. Once the PHM Service RSS and Risk Tiering functionality is available for use by Contractor, Contractor must use RSS and PHM Service Risk Tiers to:

1) Connect all Members, including those with rising risk, to an appropriate and available Contractor-identified level of service, including but not limited to, care management programs, Basic PHM, and Transitional Care Services; and

2) Contractor may supplement the PHM Service outputs with local data sources and methodologies.

C. Upon request, Contractor must ensure that its RSS and Risk Tiering approach is submitted to DHCS for review and approval in a form and method prescribed by DHCS.

4.3.6 Screening and Assessments

A. In accordance with 42 CFR section 438.208, Contractor must conduct an initial screening or assessment of each Member's needs within 90 days of Enrollment and share that information with DHCS, and other managed care health plans or Providers serving the Member, to prevent duplication of those activities. Contractor must make at least three attempts to contact a Member to conduct the initial screening or assessment using available modalities.

B. Contractor must conduct necessary screening and assessments to gain timely information on the health and social needs of all Members, in accordance with applicable State and federal laws and regulations, and NCQA PHM standards.

C. Contractor must abide by DHCS guidance for Member screening and assessment, including guidance for how to use the PHM Service for the screening and assessment process.

D. Contractor must monitor what percentage of required assessments are completed per the specifications above.

4.3.7 Care Management Programs

Contractor must maintain a PHM delivery infrastructure to ensure that the needs of its entire Member population are met across the continuum of care. The infrastructure must provide Members with the appropriate level of care management through person-centered interventions based on the intensity of health and social needs and services required. The care management interventions described in this Subsection are intended for specific segments of the population that require more intensive engagement than the Basic PHM described in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*). Members receiving the care management services described in this Subsection must have an assigned CCM Care Manager and a Care Management Plan (CMP).

Enhanced Care Management

Enhanced Care Management (ECM) is a whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high need and/or high-cost Members**.** ECM provides systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. This benefit is intended for the highest risk Medi-Cal managed care health plan Members who meet the Populations of Focus criteria. ECM is described in Exhibit A, Attachment III, Section 4.4 (*Enhanced Care Management*).

Complex Care Management

Complex Care Management (CCM) (which equates to “Complex Case Management” as defined by NCQA) is an approach to comprehensive care management that meets differing needs of high and medium rising-risk Members through both ongoing, chronic Care Coordination and interventions for episodic, temporary needs. The overall goal of CCM is to help Members regain optimum health or improved functional capability, in the right setting, and in a cost-effective manner. Contractor must consider CCM to be an opt-out program, i.e. Members have the right to participate or to decline to participate.

Both ECM and CCM are inclusive of Basic PHM, which Contractor must provide to all Members, at minimum. Care Managers conducting ECM or CCM must integrate all elements of Basic PHM into their ECM or CCM approach.

A. Care Management Programs

Contractor must operate and administer the following care management programs:

1) ECM as described in Exhibit A, Attachment III, Section 4.4 (*Enhanced Care Management*).

2) CCM

a) Contractor must operate and administer CCM in accordance with all NCQA CCM standards and requirements, and coordinate services for high and medium/rising-risk Members through Contractor's CCM approach. To the extent NCQA's standards are updated, Contractor must comply with most recent standards. Contractor must maintain and provide DHCS with policies and procedures that, at a minimum, include the following details regarding its CCM program:

i. Contractor's CCM program must be designed and implemented to help Members gain or regain optimum health or improved functional capability in the right setting;

ii. Contractor's CCM program must include comprehensive assessment of the Member's condition; determination of available benefits and resources; and development and implementation of a CMP with performance goals, monitoring and follow-up;

iii. Contractor's CCM program must have an opt-out method under which Members meeting criteria for CCM have the right to decline to participate;

iv. Contractor's CCM program must include a variety of interventions for Members that meet the differing needs of high and medium/rising-risk populations,

Back to Agenda Back to Item

including longer-term chronic Care Coordination and interventions for episodic, temporary needs;

v. Contractor's CCM program must incorporate disease-specific management programs (including, but not limited to, asthma and diabetes) that include self-management support and health education;

vi. For Members under age 21, Contractor's CCM program must include Early Periodic Screening, Diagnosis and Testing (EPSDT); all Medically Necessary services, including those that are not necessarily covered for adult Members, must be provided as long as they could be Medi-Cal-services.

b) Contractor must assess Members for the need for Community Supports as part of its CCM program to eligible Members.

c) A description of the CCM program must be included, in a manner to be prescribed by DHCS, in Contractor's annual PHMS for DHCS review and approval, outlining all the components of its CCM program, including all those listed in this Subsection.

B. CCM Care Manager Role

1) Assignment of CCM Care Manager

a) Contractor must identify and assign a CCM Care Manager for every Member receiving CCM. Following NCQA requirements, Contractor may delegate CCM to Network Providers or other entities that are NCQA-certified. PCPs may be assigned as CCM Care Managers when they are able to meet all the requirements specified in this Subsection.

b) When a CCM Care Manager other than the Member's PCP is assigned, Contractor must provide the Member's PCP with the identity of the Member's assigned CCM Care Manager, and a copy of the Member's CMP.

c) When multiple Providers perform separate aspects of Care Coordination for a Member, Contractor must:

i. Identify a lead CCM Care Manager and communicate the identity of the Care Manager to all treating Providers and the Member; and

ii. Maintain policies and procedures to ensure compliance and non-duplication of Medically Necessary services and delegation of responsibilities between Contractor and the Member's Providers in meeting all care management requirements.

2) CCM Care Manager Responsibilities

a) Contractor is responsible for ensuring CCM Care Managers comply with all of the Basic PHM requirements in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*) and all NCQA CCM standards.

b) Contractor must ensure that the CCM Care Manager performs the following duties:

i. Conduct Member assessments as needed to identify and close any gaps in care and address the Member's physical, mental health, Substance Use Disorder (SUD), developmental, oral health, dementia, palliative care, chronic disease, and LTSS needs as well as needs due to SDOH;

ii. Complete a CMP for all Members receiving CCM, consistent with the Member's goals in consultation with the Member. The CMP must:

a. Address a Member's health and social needs, including needs due to SDOH;

b. Be reviewed and updated at least annually, upon a change in Member's condition or level of care, or upon request of the Member;

c. Be in an electronic format and a part of the Member's Medical Record, and document all of the Member's services and treating Providers;

d. Be developed using a person-centered planning process that includes identifying, educating, and training the Member's parents, family members, legal guardians, Authorized Representatives (ARs), caregivers, or authorized support persons, as needed; and

e. Include referrals to community-based social services and other resources even if they are not Covered Services under this Contract.

iii. Ensure continuous information sharing and communication with the Member and their treating Providers; and

iv. Specify the responsibility of each Provider that provides services to the Member.

c) Ensure Members receive all Medically Necessary services, including Community Supports, to close any gaps in care and address the Member's mental health, SUD, developmental, physical, oral health, dementia, palliative care needs as well as needs due to SDOH;

d) Support and assist the Member in accessing all needed services and resources, including across the physical and Behavioral Health delivery systems;

e) Communicate to Members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate;

f) Provide referrals to Community Health Workers (CHWs), peer counselors, and other community-based social services including, but not limited to, personal care services, LTSS, Community Supports and local community organizations and other programs or services offered by other agencies and third-party entities with which Contractor has or will have a MOU;

g) Assess the Member's understanding of the referral instructions and follow-up to determine whether the referral instructions were completed or whether the Member needs

further assistance to access the services, and if so, provide such assistance;

h) Review and/or modification of Member's CMP, when applicable, to address unmet service needs;

i) Facilitate and encourage the Member's adherence to recommended interventions and treatment; and

j) Ensure timely authorization of services to meet the Member's needs in accordance with the Member's CMP.

4.3.8 Basic Population Health Management

A. Contractor must provide Basic PHM to all Members, in accordance with 42 CFR section 438.208. Contractor must maintain policies and procedures that meet the following Basic PHM requirements, at a minimum:

1) Ensure that each Member has an ongoing source of care that is appropriate, ongoing and timely to meet the Member's needs;

2) Ensure Members have access to needed services including Care Coordination, navigation and referrals to services that address Members' developmental, physical, mental health, SUD, dementia, LTSS, palliative care, and oral health needs;

3) Ensure that each Member is engaged with their assigned PCP and that the Member's assigned PCP plays a key role in the Care Coordination functions described in this Subsection, in partnership with Contractor;

4) Ensure each Member receives all needed preventive services in partnership with the Member's assigned PCP;

5) Ensure efficient Care Coordination and continuity of care for Members who may need or are receiving services and/or programs from out-of-Network Providers;

6) Ensure Members are provided with resources and education about how to access the various programs and services offered by agencies and third-party entities with whom Contractor has or will have an executed MOU;

7) Review Member utilization reports to identify Members not using Primary Care; stratify such reports, at minimum, by race and ethnicity to identify Health Disparities that result from differences in utilization of outpatient and preventive services; and develop strategies to address differences in utilization;

8) Facilitate access to care for Members by, at a minimum, helping to make appointments, arranging transportation, ensuring Member health education on the importance of Primary Care for Members who have not had any contact with their assigned Medical Home/PCP or have not been seen within the last 12 months, particularly Members less than 21 years of age;

9) Ensure all services are delivered in a culturally and linguistically competent manner that promotes Health Equity for all Members;

10) Coordinate health and social services between settings of care, across other Medi-Cal managed care health plans, delivery systems, and programs (e.g., Targeted Case Management, Specialty Mental Health Services), with external entities outside of Contractor's Network, and with Community Supports and other community-based resources, even if they are not Covered Services under this Contract, to address Members' needs and to mitigate impacts of SDOH;

11) Coordinate referrals to ensure Care Coordination with public benefits programs, including without limitation, as required by this Contract under the requirements set forth for Memorandums of Understanding (MOUs) in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*);

12) Assist Members, Members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons with navigating health delivery systems, including Contractor's Subcontractor and Downstream Subcontractor Networks, to access Covered Services as well as services not covered under this Contract;

13) Provide Members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes;

14) Communicate to Members' parents, family members, legal

Back to Agenda Back to Item

guardians, ARs, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate;

15) Ensure that Providers furnishing services to Members maintain and share, as appropriate, Members' Medical Records in accordance with professional standards and State and federal law;

16) Facilitate exchange of necessary Member Information in accordance with any and all State and federal privacy laws and regulations, including data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with H&S section 130290, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable; and

17) Maintain processes to ensure no duplication of services occurs.

B. Wellness and Prevention Programs

1) Contractor must provide wellness and prevention programs that meet NCQA PHM standards, including for the provision of evidence-based self-management tools;

2) Contractor must ensure that the wellness and prevention programs align with the DHCS Comprehensive Quality Strategy;

3) Contractor must provide wellness and prevention programs in a manner specified by DHCS, and in collaboration with LGAs as appropriate, that include the following, at a minimum:

a) Identification of specific, proactive wellness initiatives and programs that address Member needs;

b) Evidence-based disease management programs including, but not limited to, programs for diabetes, cardiovascular disease, asthma, and depression that incorporate health education interventions, target Members for engagement, and seek to close care gaps for Members participating in these programs;

c) Initiatives, programs, and evidence-based approaches to improving access to preventative health visits, developmental screenings and services for Members less than 21 years of age, as described in Exhibit A, Attachment

Back to Agenda Back to Item

III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*);

d) Initiatives, programs, and evidence-based approaches on improving pregnancy outcomes for women, including through 12 months post-partum;

e) Initiatives, programs, and evidence-based approaches on ensuring adults have access to Preventive Care, as described in Exhibit A, Attachment III, Subsection 5.3.5 (*Services for Adults*) and in compliance with all applicable State and federal laws;

f) A process for monitoring the provision of wellness and preventive services by PCPs as part of Contractor's Site Review process, as described in Exhibit A, Attachment III, Subsection 5.2.14 (*Site Review*);

g) Health education materials, in a manner that meets Members' health education and cultural and linguistic needs, in accordance with Exhibit A, Attachment III, Subsection 5.3.7 (*Services for All Members*); and

h) Initiatives and programs that implement evidence-based best practices that are aimed at helping Members set and achieve wellness goals.

4) Contractor must ensure that its wellness and prevention programs are submitted to DHCS for review and approval in a form and method prescribed by DHCS.

5) Contract must report annually through the PHMS on how community-specific information and stakeholder input from the PNA is used to design and implement evidence-based wellness and prevention strategies.

4.3.9 Other Population Health Requirements for Children

For Members less than 21 years of age, Contractor must provide as part of care management and Basic PHM the following services for Children:

A. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Case Management Responsibilities

Contractor must provide case management to assist Members less than 21 years of age in gaining access to all Medical Necessary medical, Behavioral Health, dental, social, educational, and other services, as defined in 42 United States Code (USC) sections 1396d(a), 1396d(r), and 1396n(g)(2), and Welfare and Institutions Code (W&I) section 14059.5(b). Case management services for Members less than 21 years of age also include the data exchange necessary for the provision of services as well as the coordination of non-covered services such as social support services. Additionally, Contractor must provide EPSDT case management services as Medically Necessary services for Members less than 21 years of age, as required in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*), and must ensure that all Medically Necessary services for Members less than 21 years of age are initiated within timely access standards whether or not the services are Covered Services under this Contract.

B. Children and Youth with Special Health Care Needs

Contractor must develop and implement policies and procedures to provide services for C**Y**SHCN. Contractor must ensure that the policies and procedures include the following information, at a minimum, to encourage C**Y**SHCN Member participation:

1) Methods for ensuring and monitoring timely access to pediatric Specialists, sub-Specialists, ancillary therapists, transportation, and Durable Medical Equipment (DME) and supplies. These may include assignment to a Specialist as PCP, Standing Referrals, or other methods.

2) Methods for monitoring and improving the quality, Health Equity and appropriateness of care for CYSHCN.

3) Methods for ensuring Care Coordination with Department of Developmental Services (DDS), local health departments and local California Children's Services (CCS) Programs, as appropriate and as required under any applicable MOUs between Contractor and local health departments and DDS for the CCS Program.

C. Early Intervention Services

Contractor must develop and implement systems to identify Members who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. These Members include those with a condition known to lead to developmental delay, those in whom a

Back to Agenda Back to Item

developmental delay is suspected, or whose early health history places them at risk for delay. Contractor must collaborate with the local RC or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members. Contractor must provide case management and Care Coordination to the Member to ensure the provision of all Medically Necessary Covered Services identified in the Individualized Family Service Plan (IFSP) developed by the Early Start program, with PCP participation.

4.3.10 Transitional Care Services

Contractor must provide Transitional Care Services (TCS) to all Members transferring from one setting, or level of care, to another in accordance with 42 CFR section 438.208, other applicable federal and State laws and regulations, APL 22-024, and the PHM Policy Guide. Transferring from one setting, or level of care, to another includes, but is not limited to, discharges from hospitals, institutions, acute care facilities, and Skilled Nursing Facilities (SNFs) to home or community-based settings, Community Supports, post-acute care facilities, or Long-Term Care (LTC) settings.

Contractor must identify every Member undergoing a transition as high-risk or lower-risk according to the criteria in the PHM Policy Guide.

For all identified high-risk Members, Contractor must ensure a Member has a single point of contact for the duration of the transition. If a Member identified as high risk is not receiving CCM or ECM, Contractor must identify a care manager who is a single point of contact responsible for ensuring the completion of all Transitional Care Services, including making referrals and ensuring no gaps in care. For Members identified as lower risk, a single point of contact is not required, but there must be a dedicated care management team available, as described further in the PHM Policy Guide.

Contractor must ensure that TCS processes meet the requirements of A-C below, for both high and lower risk Members. The PHM Policy Guide describes in further detail how the requirements below apply to high and lower risk Members.

Additional guidance is forthcoming on the specific TCS requirements for different populations.

A. General Requirements for Transitional Care Applicable to All Members in Transition, including High- and Lower-Risk Members

Contractor must implement transitional care processes that meet the following further requirements as specified in the PHM Policy Guide, at

minimum:

1) Ensure each Member is evaluated for all care settings appropriate to the Member's condition, needs, preferences and circumstances. Members must not be discharged to a setting that does not meet their medical and/or LTSS needs;

2) Ensure that permission is obtained from Members, Members' parents, legal guardians, or ARs, as appropriate to share information with Providers to facilitate transitions, in accordance with federal and State privacy laws and regulations;

3) Ensure referrals to Community Supports and coordination with county social service agencies and waiver agencies for In-Home Supportive Services (IHSS) and other Home and Community-Based Services (HCBS) for Members who may be eligible for such services, and in accordance with any MOU executed between Contractor and such agencies;

4) Ensure referrals to ECM and Community Supports for Members identified as having unstable housing, experiencing homelessness, or needing nursing facility care, for whom transition to home/assisted living facility or short term post hospitalization/recuperative care are alternatives;

5) Ensure all Prior Authorizations required for the Member's discharge are processed within timeframes consistent with the urgency of the Member's condition, not to exceed five Working Days for routine authorizations, or 72 hours for expedited authorizations, in accordance with Exhibit A, Attachment III, Subsection 2.3.2 (*Timeframes for Medical Authorization*). Prior Authorizations should be complete prior to discharge. This includes Prior Authorizations for therapy, home care, medical supplies, prescription medications for which Contractor is responsible, and DME that are processed in accordance with 42 CFR section 438.210, H&S section 1367.01, and Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*) of this Contract;

6) Ensure all Network Provider hospitals, institutions, and facilities educate their Discharge Planning staff on the services, supplies, medications, and DME needing Prior Authorization;

7) Ensure that mutually agreed-upon policies and procedures for Discharge Planning and Transitional Care Services exist between

Back to Agenda Back to Item

Contractor and each of its Network Provider and out-of-Network Provider hospitals within its Service Area;

8) Prevent delayed discharges of a Member from a hospital, institution, or facility due to circumstances such as, but not limited to, Contractor authorization procedures or transitions to a lower level of care, by determining and addressing the root causes of why delays occur;

9) Require all of its contracted hospitals, and all SNFs with electronic health records, to send Admission, Discharge, and Transfer (ADT) notifications to Contractor for each of its assigned Members in accordance with Interoperability and Patient Access Final Rule set forth at CMS-9115-F, and in accordance with the California Health and Human Services Data Exchange Framework set forth in H&S section 130290, and as further specified in the PHM Policy Guide; and

10) Ensure all Members being discharged from discharging facilities, including SNFs, have a PCP who can provide follow-up care, as appropriate, and that the discharging facilities have contact information for PCPs.

B. Responsibility to Ensure Completion of Facility's Discharge Planning Process, Including Member Engagement for All Members, Including Both High and Lower Risk Members.

Contractor must ensure the discharging facility completes a Discharge Planning process that engages Members, Members' parents, legal guardians, or Authorized Representatives, as appropriate, when being discharged from a hospital, institution or facility. Contractor must ensure that the facility's process is consistent with CMS Conditions of Participation, State regulations, and Joint Commission Requirements, as applicable, including as follows:

1) Contractor must ensure the discharging facility focuses on the Member's goals and treatment preferences during the discharge process, and that they are documented in the Medical Record. Contractor must ensure the discharging facility uses a consistent assessment process and/or assessment tools to identify Members who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.

a) For high-risk Members, Contractor must ensure the facility shares this information with the care manager. Contractor must also ensure the discharging facility has processes and procedures in place to refer Members to ECM or Community Supports as needed.

b) For lower risk Members, Contractor must ensure the hospital has processes and procedures to leverage this assessment to identify Members who may benefit from services and refer Members to Contractor for high risk TCS, ECM, or Community Supports.

2) For discharge instructions, Contractor must ensure that the Member and their designated caregiver are informed of the continuing health care requirements following discharge from the facility. This information must include, but is not limited to, education and counseling about the Member's medications, including dosing and proper use of medication delivery devices, when applicable. The information must be provided in a culturally and linguistically appropriate format to the Member and caregiver, and must include the opportunity for the caregiver to ask questions about the post-hospital needs of the Member per H & S section 1262.5.

3) For discharge coordination, Contractor must ensure discharging facility has process in place for coordinating care with the following:

a) For Member's designated family caregiver, Contractor must ensure the discharging facility has processes to ensure Member's designated family caregiver is notified of the Member's discharge or transfer to another facility per H&S section 1262.5.

b) For post-discharge Providers, Contractor must ensure discharging facility provides necessary clinical information to the appropriate post-discharge Providers, including the discharge summary per 42 CFR section 482.43.

C. Transitional Care Services for High and Lower Risk Members

1) Contractor must identify every Member undergoing a transition as high risk or lower-risk. For the criteria for high and lower-risk, and detailed requirements for each, refer to the PHM Policy Guide.

2) For Members identified as high risk, Contractor must ensure the Member has a single point of contact for the duration of the transition who is responsible for ensuring a successful transition. If the Member is receiving CCM or ECM, Contractor must ensure that the Member's assigned care manager provides all TCS. The single point of contact is responsible for:

   a) Outreach to Member;

   b) Assessing Member's risk for adverse outcomes to inform needed TCS and identify Members that may require ECM, CCM (if not already enrolled), or Community Supports, using the discharging facility data and Member engagement;

   c) Reviewing facility discharge summary;

   d) Ensuring Member receives appropriate discharge instructions;

   e) Ensuring follow up Providers receive appropriate clinical information;

   f) Ensuring medication reconciliation is complete post discharge;

   g) Ensuring Members with SUD and mental health needs receive treatment for those conditions upon discharge;

   h) Ensuring the completion of all recommended follow-up, including any needed specialty or primary care follow-up, any SUD or mental health treatment, or any needed community or home-based services.

3) For Members identified as lower risk, Contractor must, in addition to meeting all general requirements in Paragraphs A and B above:

   a) Ensure Member has, at minimum, telephonic access to a dedicated TCS team for at least 30 days from the discharge. The team must:

      i. Be able to access the Member's discharge documents to be able to assist Member with questions, including but not limited to medication changes;

Back to Agenda Back to Item

ii. Assist Member with any TCS needs identified by Member, including but not limited to access to ambulatory care, appointment scheduling, referrals, arranging Non-Emergency Medical Transport (NEMT);

iii. Provide escalation to meet any TCS needs as needed, including connecting Members with a licensed Provider, if necessary; and

iv. Place and coordinate referrals to longer term care management programs such as ECM/CCM, and/or Community Supports for eligible Members at any point in the transition.

b) Ensure Member can access the TCS team through a dedicated phone number as follows:

i. During business hours, Contractor must ensure Members can connect with live TCS team member within no more than one automated phone selection option.

ii. Outside of business hours, Members must be able to be referred to Emergency Services as needed and be able to leave a message. TCS team must respond to Members within one Working Day of message.

iii. Contractor must ensure the Member is notified of the TCS support team and phone line directly, and make best efforts to ensure Member is notified directly within 24 hours of discharge.

c) Ensure Member completes follow-up with ambulatory PCP, Specialist, or advanced practice Provider that has prescribing authority within 30 calendar days to ensure medication reconciliation. For a Member who has not had a visit with their assigned PCP within the last 12 months, ensure the Member completes PCP follow-up in addition to any necessary non-primary care ambulatory visits within 30 calendar days.

d) Use data from discharges to assess and identify Members

that may newly qualify for ECM/CCM or Community Supports.

D. Nursing Facility Transitions

1) For diversion from the need for a nursing facility with supports, Contractor must evaluate all Members who have been identified as requiring nursing facility care for Community Supports. This includes the following, as appropriate: short term post-hospitalization, recuperative care, and respite services; day habilitation services; Community Supports supporting transitions to home, or a Residential Care Facility for the Elderly/ Adult Residential Facility, and personal care/homemaker services; as well as for ECM, IHSS, and/or waiver programs that may allow the Member to live at home or in alternative settings with support, as aligned with the Member's goals.

2) When transitioning Members to and from SNFs, Contractor must comply with APL 23-004. Contractor must ensure timely Member transitions that do not delay or interrupt any Medically Necessary services or care by meeting the following requirements, at a minimum:

a) Coordinate with facility discharge planners, care or Case Managers, or social workers to provide case management and Transitional Care Services during all transitions;

b) Assist Members being discharged or Members' parents, legal guardians, or ARs by evaluating all medical needs and care settings available including, but not limited to, discharge to a home or community setting, and referrals and coordination with IHSS, Community Supports, LTSS, and other HCBS programs;

c) Maintain contractual requirements for SNFs to share Minimum Data Set (MDS) Section Q, have appropriate systems to import and store MDS Section Q data and incorporate MDS Section Q data into transition assessments;

d) Ensure all Members being discharged from nursing facilities, have a PCP that can provide follow-up care, as appropriate, and that the discharging facilities have contact information for PCPs;

e) Ensure Member outpatient appointment(s) or other immediate follow-ups are scheduled prior to discharge;

f) Verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting and have their medical needs met; and

g) Follow-up with Members, Members' parents, legal guardians, or ARs, as appropriate, regarding the new care setting to ensure compliance with Transitional Care Services requirements.

4.3.11 Targeted Case Management Services

A. Contractor must identify the target populations for Targeted Case Management (TCM) programs within their Service Area, and maintain procedures to refer Members to TCM services. If upon notification from DHCS that Members are receiving TCM services Contractor is not already aware of, Contractor must reach out to LGAs to coordinate care, as appropriate.

B. Contractor must coordinate with LGAs to provide Care Coordination for all Medically Necessary Covered Services identified by TCM Providers in their Member care plans, including referrals and Prior Authorization for out-of-Network medical services. Coordination with LGAs must continue for Members receiving TCM services until the LGA notifies Contractor that TCM services are no longer needed for the Member.

C. Because TCM can be a direct duplication of services such as, but not limited to, Basic PHM, CCM, ECM, and Community Supports, Contractor must have processes to ensure Members receiving TCM are not receiving duplicative services. For specific guidance on ECM overlap with county-based TCM, see the ECM Policy Guide.

D. Contractor must designate a representative responsible for coordinating TCM services with LGAs for the Member. Contractor representative's responsibilities include, but are not limited to, sharing the appropriate Member Provider(s) information and PCP and/or Care Manager assignment with LGAs and resolving all related operational issues.

E. Contractor must also notify Members' PCPs and/or Care Managers when Members are receiving TCM services and provide them with the appropriate LGA contact information.

F. For Members less than 21 years of age, Contractor must ensure that all Medically Necessary services are provided timely as required in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age)*. Notwithstanding medical services recommended in TCM care plans or arranged by LGAs or TCM Providers for Members less than 21 years of age, Contractor remains responsible for the provision of the EPSDT benefit, as described in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*).

4.3.12 Mental Health Services

Contractor must use DHCS-approved standardized screening tools as identified in APL 22-028 to ensure Members seeking mental health services who are not currently receiving Non-specialty Mental Health Services (NSMHS) or Specialty Mental Health Services (SMHS) receive referrals to the appropriate delivery system for mental health services, either in Contractor's Network or the MHP network, in accordance with the No Wrong Door policies set forth in W&I section 14184.402(f) and specified in Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*).

A. Non-specialty Mental Health Services

Contractor must provide timely NSMHS for Members consistent with the No Wrong Door policies even when:

1) NSMHS were provided:

a) During the assessment process;

b) Prior to determination of a diagnosis; or

c) Prior to determination of whether NSMHS criteria set forth in W&I section 14184.402(b)(2) are met;

2) NSMHS were not included in a Member's individual treatment plan;

3) Member has a co-occurring mental health condition and SUD; or

4) NSMHS are provided to a Member concurrently with SMHS, if those services are not duplicative and coordinated between Contractor and the MHP.

B. Specialty Mental Health Services

1) Contractor must maintain policies and procedures to refer Members who meet the criteria for SMHS to the MHP in accordance with the No Wrong Door policies.

2) Contractor must also enter into a MOU with the MHP in accordance with Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) to ensure services for its Members are properly coordinated and provided in a timely and non-duplicative manner.

3) If a Member receiving NSMHS is determined to meet the criteria for SMHS due to a change in the Member's condition, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2 (*Non-specialty Mental Health Services and Substance Use Disorder Services*), and continue to provide NSMHS to the Member concurrently receiving SMHS when those services are not duplicative and coordinated between Contractor and the MHP.

C. Mental Health Services Disputes

1) Disputes between Contractor and MHP must not delay the provision of Medically Necessary services by Contractor or MHP.

2) If Contractor and MHP cannot agree on the appropriate place of care, disputes must be resolved pursuant to APL 21-013, and as specified in Exhibit A, Attachment III, Subsection 5.5.5 (*Mental Health and Substance Use Disorder Services Disputes*). Specifically, as set forth in APL 21-013, Contractor and MHPs must complete the plan level dispute resolution process within 15 Working Days of identifying the dispute.

3) Contractor and MHP may seek to enter into an expedited dispute resolution process if a Member has not received a disputed service(s) and Contractor and/or MHP determine that the routine dispute resolution process timeframe would result in serious jeopardy to the Member's life, health, or ability to attain, maintain, or regain maximum function. Under this expedited process, Contractor and MHP will have one Working Day after identification of a dispute to attempt to resolve the dispute at the plan level. All terms and requirements established in APL 21-013 apply to disputes between Contractor and MHP.

4.3.13 Alcohol and Substance Use Disorder Treatment Services

A. Contractor must identify and refer Members requiring alcohol and/or SUD treatment services to the County Department responsible for alcohol and SUD treatment, other community resources when services are not available through the County Department, or to outpatient heroin and other opioid detoxification Providers available through the Medi-Cal Fee-For-Service (FFS), as appropriate. Contractor must assist Members in locating available treatment service sites. To the extent that alcohol and/or SUD treatment services are not available within Contractor's Service Area, Contractor must coordinate with the County Department responsible for SUD treatment to refer Members to available treatment outside of Contractor's Service Area.

B. Contractor must have MOUs with each County Department responsible for alcohol and SUD treatment services within Contractor's Service Area in accordance with the MOU requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*). The MOU must delineate the roles and responsibilities between Contractor and County Departments for coordinating care, and ensuring non-duplication of services and timeliness of care for the Members.

C. For Members receiving alcohol and SUD treatment services through County Departments, Contractor must continue to provide all Medically Necessary Covered Services and coordination and referral of services between its Network Providers and other treatment programs for the Member.

D. Prescribing and medication management of buprenorphine and other prescribed medications for SUD treatment (also known as medication-assisted treatment or MAT) are the responsibility of Contractor when they are provided in Primary Care offices, departments, hospitals, or other contracted medical facilities.

E. Contractor must enter into a data sharing agreement with the County Department responsible for alcohol and SUD treatment, other community resources when services are not available through the County Department, or to outpatient opioid disorder treatment. Contractor's data sharing agreement with such County Departments must also require such County Departments, and all Part 2 programs contracting with such County Departments that provide services to Members, to use authorization forms that align with DHCS data sharing and authorization guidance for the disclosure of information that
provide the following:

Back to Agenda Back to Item

1) Comply with 42 CFR part 2;

2) Name both Contractor and DHCS as potential recipients of the data being disclosed;

3) Indicate that Contractor and DHCS are permitted to use such data for payment and health care operations purposes, as defined by HIPAA; and

4) If 42 CFR Part 2 is modified to permit such a practice, include a statement indicating that any information disclosed to a covered entity or business associate may be redisclosed to the extent permitted by the HIPAA privacy rule, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient.

4.3.14 California Children's Services

A. Notwithstanding any other provisions in W&I section 14094.4 *et seq*. for Contractors operating in COHS counties, Contractor must maintain policies and procedures to identify and refer Members with a potential California Children's Services (CCS)-Eligible Conditions to the local CCS Program for determination of CCS eligibility. These policies and procedures must include the following, at a minimum:

1) The requirement that Network Providers complete the appropriate baseline health assessments and diagnostic evaluations, which provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a potential CCS-Eligible Condition;

2) The requirement that Contractor supports CCS program referral pathways in the non-Whole Child Model counties including but not limited to identifying children who may be eligible for the CCS program through internal reports, Provider directed referrals, or direct referrals from Contractor;

3) Instruct Network Providers that CCS reimburses only CCS-paneled Providers and CCS-approved hospitals within Contractor's Network, and that reimbursement is only from the date of referral;

4) The requirement that Network Providers complete the initial referrals of Members with suspected CCS-Eligible Conditions same day using modalities accepted by the local CCS Program. The

initial referral must be followed by submission of supporting medical documentation sufficient to allow for CCS eligibility determination by the local CCS Program;

5) Instruct Network Providers of their requirement to continue to provide all Covered Services to the Member until CCS Program eligibility is confirmed;

6) The requirement that once eligibility for the CCS Program is established for a Member, Contractor must continue to provide all Covered Services that are not authorized by CCS Program and must ensure the coordination of services and joint case management between the Member's PCP, CCS Providers, and the local CCS Program. Contractor must continue to provide case management services to ensure all Covered Services authorized through the CCS Program are provided timely as required in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*). Without limitation, Contractor must, as necessary, including upon a Member's request, arrange for all in-home nursing hours authorized by the CCS Program that a Member desires to utilize, as required by APL 20-012; and

7) The requirement that Contractor ensure all Medically Necessary Covered Services are provided to the Member if the local CCS Program does not approve CCS Program eligibility. If the local CCS Program denies authorization for any service, Contractor remains responsible for providing and reimbursing for the cost of the ser vice if it is determined to be Medically Necessary.

B. Authorization for payment must be retroactive to the date the CCS Program was informed about the Member through an initial referral by Contractor or a Network Provider. In an emergency admission, Contractor or a Network Provider must be allowed until the next Working Day to inform the CCS Program about the Member.

C. Contractor must maintain policies and procedures for identifying CCS-eligible Members that are aging out of the CCS Program. Within 12 months of a CCS Member aging out of the program, Contractor must develop a Care Coordination plan to assist the Member in transitioning out of the CCS Program. The policies and procedures must include, the following, at a minimum:

1) Identifying the Member's CCS-Eligible Condition; and any other programs the Member may be eligible for based upon their CCS eligible condition;

2) Planning for the needs of the Member to transition from the CCS Program;

3) A communication plan with the Member in advance of the transition;

4) Identification and coordination of Primary Care and specialty care Providers appropriate to the Member's CCS-Eligible Condition(s); and

5) Continued assessment of the Member through first 12 months of the transition.

D. Contractor must have Memorandums of Understanding (MOUs) with each CCS Program within its Service Area that are in accordance with the MOU requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*). The MOU must delineate the roles and responsibilities of Contractor and the CCS Program for coordinating care and ensuring the non-duplication of services.

4.3.15 Services for Persons with Developmental Disabilities

A. Contractor must maintain policies and procedures for identifying and tracking Members with Developmental Disabilities (DD), including all services they receive.

B. Contractor must designate its own liaison to coordinate with each RC operating within Contractor's Service Area to assist Members with DD in understanding and accessing services, and to act as a central point of contact for questions, access and care concerns, and problem resolution, as required by W&I section 14182(c)(10).

C. Contractor must refer Members with DD to a RC for evaluation and for access to non-medical services provided by the RC, including, but not limited to, respite, out-of-home placement, and supportive living. Contractor must have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to coordinate services for the Member with RC staff to ensure the non-duplication services and to create

the individual developmental services plan required for all Members with DD, which includes identification of the Member's medical needs and the provision of Medically Necessary services such as medical care, NSMHS, and Behavioral Health Treatment (BHT).

D. Contractor must maintain policies and procedures to identify and refer eligible Members to the HCBS program administered by the Department of Developmental Services (DDS).

E. Contractor must refer to Exhibit A, Attachment III, Subsection 4.3.20 (*Home and Community-Based Services Programs*) for further coordination of care requirements related to providing HCBS programs through the HCBS-DD Waiver.

4.3.16 School-Based Services

A. Contractor must have an MOU in place with all LEAs in its Service Area in accordance with Exhibit A, Attachment III, Section 5.6 (*MOUs with Third Parties*) to ensure there are processes that account for facilitating cooperation and collaboration between the Member's PCP and the LEA in the development of the Member's Individualized Education Plan (IEP) or the IFSP. Contractor must provide case management and Care Coordination to the Member, or the parent, legal guardian, or AR, to ensure the provision of all Medically Necessary Covered Services identified in the IEP developed by the LEA, with PCP participation.

B. Contractor must cover Medically Necessary mental health and SUD services as specified by DHCS when delivered by school-linked behavioral health providers to a Member who is 25 years of age or younger. Contractor must cover these services in accordance with DHCS guidance related to the Children and Youth Behavioral Initiative (CYBHI) and at the DHCS established fee schedule Contractor must execute agreements in accordance with DHCS guidance and in accordance with H&S section 1374.722 and W&I section 5963.4(c).

C. By 2025, Contractor is required to provide Covered Services, including preventive services and adolescent health services provided in schools or by school-affiliated health providers.

D. Contractor must implement interventions that increase access to preventive, early intervention, and Behavioral Health Services by school-affiliated Behavioral Health Providers for Children in publicly funded childcare and preschool, and TK-12 Children in public schools, in

accordance with the interventions, goals, and metrics set forth in W&I section 5961.3(b).

4.3.17 Dental

A. Contractor must cover and ensure that dental screenings and oral health assessments are included for all Members. Contractor must ensure that all Members are given referrals to appropriate Medi-Cal dental Providers. Contractor must provide Medically Necessary Federally Required Adult Dental Services (FRADS), fluoride varnish, and dental services that may be performed by a medical professional. Dental services that are exclusively provided by dental Providers are not covered under this Contract.

B. For Members less than 21 years of age, Contractor must ensure that a dental screening and an oral health assessment are performed as part of every periodic assessment, with annual dental referrals beginning with the eruption of the Member's first tooth or at 12 months of age, whichever occurs first.

C. Contractor must ensure the provision of Medically Necessary dental-related Covered Services that are not exclusively provided by dentists or dental anesthetists. Contractor must also have an identified Contractor liaison available to Medi-Cal dental Providers to assist with referring the Member to other Covered Services. Other Covered Services include, but are not limited to laboratory services, and pre-admission physical examinations required for admission to an outpatient surgical service center, or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services). Contractor may require Prior Authorization for Medically Necessary Covered Services needed in support of dental procedures.

   If Contractor requires Prior Authorization in support of dental procedures, Contractor must develop and publish the policies and procedures for obtaining Prior Authorization for dental services to ensure that services are provided to the Member in a timely manner. Contractor must coordinate with DHCS Medi-Cal Dental Services Division in the development of their policies and procedures pertaining to Prior Authorization for dental services and must submit such policies and procedures to DHCS for review and approval.

4.3.18 Direct Observed Therapy for Treatment of Tuberculosis

Contractor must assess the risk of treatment resistance or noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis drug therapy.

A. The following groups are at risk for treatment resistance or noncompliance for the treatment of Tuberculosis (TB):

1) Members with demonstrated resistance to Isoniazid and Rifampin;

2) Members whose treatment has failed or who have relapsed after completing a prior regimen;

3) Substance users;

4) Members with mental health conditions or SUD;

5) Elderly, Children and adolescent Members;

6) Members with unmet housing needs;

7) Members with language and/or cultural barriers; and

8) Members who have demonstrated noncompliance by failing to keep office appointments.

B. Contractor must refer Members with active TB and Members who have treatment resistance or non-compliance issue risks to the TB control officer of the LHD for Direct Observed Therapy (DOT). If a Provider finds that a Member is at risk for treatment resistance or noncompliance with treatment, Contractor must refer the Member to the LHD for DOT.

C. Contractor must have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to ensure joint case management and Care Coordination with the LHD TB Control Officer. Contractor must provide all Medically Necessary Covered Services to Members with TB on DOT.

4.3.19 Women, Infants, and Children Supplemental Nutrition Program

A. Women, Infants, and Children (WIC) services are not covered under this Contract. However, Contractor must maintain procedures to identify and refer eligible Members for WIC services. Contractor must also have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (*MOUs*

with Local Government Agencies, County Programs, and Third Parties) to ensure referrals. As part of the referral process, Contractor must provide the WIC program with the Member's current hemoglobin or hematocrit laboratory value. Contractor must also document the laboratory values and the referral in the Member's Medical Record.

B. Contractor must refer, and document the referral of, Members who are pregnant, breastfeeding, or postpartum, or a legal guardian for a Member under the age of five, to the WIC program either as part of the initial evaluation of newly pregnant women pursuant to 42 CFR section 431.635(c) and PL 98-010.

4.3.20 Home and Community-Based Services Programs

A. DHCS administers, either directly or through another State entity, a number of Medi-Cal Home and Community-Based Services (HCBS) programs authorized under the Medi-Cal program. HCBS programs provide long-term community-based services and supports to eligible Members in the community setting of their choice instead of in an institution.

B. Contractor must continue to provide all Covered Services to a Member when that Member is enrolled in, or applying to enroll in, receiving, or applying to receive an HCBS program other than this Contract. Contractor must continuously collaborate and exchange Member health care and medical information with all third-party entities providing the Member with Medi-Cal HCBS or administering a Medi-Cal-funded HCBS program pursuant to the third-party entity's contractual or legal authority to administer Medi-Cal-funded HCBS programs and/or provide HCBS to the Member. Such third-party entities include, but are not limited to:

1) DHCS;

2) State departments that operate or administer Medi-Cal programs offering HCBS pursuant to legal authority and/or Inter-Agency Agreements with DHCS, including but not limited to, the California Department of Social Services; the California Department of Developmental Services, the California Department of Public Health (CDPH), and the California Department of Aging;

3) Home and Community Based Alternatives Waiver agencies;

4) Assisted Living Waiver Care Coordination agencies;

5) RCs;

6) Multipurpose Senior Services Program sites;

7) Medi-Cal Waiver Program agencies; and

8) California Community Transitions lead organizations.

C. Contractor must maintain procedures to identify Members who may benefit from Medi-Cal HCBS programs and refer Members to the third-party entity administrating the HCBS program. The HCBS programs include, but are not limited to HCBS programs authorized under the Social Security Act (SSA) at 42 USC section 1396n(c), the California Medicaid State Plan option authorized under 42 USC section 1396n(k), California Medicaid State Plan HCBS benefits authorized under 42 USC section 1396n(k), and other State and federally-funded Medi-Cal HCBS programs. If the Member is then authorized to receive Medi-Cal-funded HCBS program services, the Member must remain enrolled with Contractor and Contractor must continue to provide all services and benefits covered under this Contract to the Member.

D. Contractor's collaboration with third-party entities providing the Member with HCBS program services or administering a HCBS program pursuant to the third-party entity's contractual or legal authority to administer HCBS programs and/or provide HCBS program services to the Member, must include, but is not limited to:

1) Maintaining staff assigned to coordinate with such third-party entities that is sufficient to assist Members in understanding and accessing HCBS program services, and to act as a central point of contact for questions, access, and Care Coordination concerns.

2) Working in collaboration with such third-party entities' care managers and Providers to coordinate Covered Services, all HCBS program services, and any other relevant medical or supportive services. Such coordination must include, but is not limited to, the timely exchange of information regarding the Member and their health care needs, services, and efforts to obtain and arrange for the provision of both Medi-Cal and non-Medi-Cal programs pursuant to DHCS guidance to Contractor and HCBS Providers.

3) As contracted delegates of the State, Contractor and such third-party entities administering HCBS programs and/or providing HCBS program services are authorized to share Member information with

one another, including PHI/Personal Identifiable Information (PII) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Exhibit G of this Contract, because both are under a contract with DHCS, are legally authorized to receive such information, and/or are responsible for administration of the Medi-Cal program, complying with the provisions within their respective Business Associate Agreements with the State, and sharing this information with each other as part of their contractual responsibilities pursuant to and in compliance with 45 CFR sections 164.502(a)(1)(ii), 164.502(a)(3), and 164.506(c).

4.3.21 In-Home Supportive Services

Contractor must maintain policies and procedures for identifying and referring eligible Members to the county IHSS program. Contractor's procedures must address the following requirements, at a minimum:

A. Processes for coordinating with the county IHSS agency that ensures Members do not receive duplicative services through ECM, Community Supports, and other services;

B. Track all Members receiving IHSS and continue coordinating services with the county IHSS agency for Members until IHSS notifies Contractor that IHSS is no longer needed for the Member;

C. Designate a person to serve, as the day-to-day IHSS liaison with county IHSS agency.

1) Contractor, in collaboration with county IHSS agency, must ensure Contractor's IHSS liaison is sufficiently trained on IHSS assessment and referral processes and providers, and how Contractor and Primary Care Providers can support IHSS eligibility applications and coordinate care across IHSS, medical services, and long-term services and supports. This includes training on IHSS referrals for Members in inpatient and Skilled Nursing Facility settings as a part of Transitional Care Service requirements, to support safe and stable transitions to home and community-based settings.

2) The IHSS liaison functions may be assigned to the LTSS liaison as long as they meet the training requirements and have the expertise to work with the county IHSS liaison.

D. Outreach and coordinate with the county IHSS agency for any Members identified by DHCS as receiving IHSS;

E. Upon identifying Members receiving, referred to, or approved for IHSS, conduct a reassessment of Members' Risk Tier, per the population RSS and Risk Tiering requirements in this Section; and

F. Continue to provide Basic PHM and Care Coordination of all Medically Necessary services while Members receive IHSS.

4.3.22 Indian Health Care Providers

Contractor must have an identified tribal liaison dedicated to working with each Indian Health Care Provider (IHCP) in its Service Area and responsible for coordinating referrals and payment for services provided to Indian Members who are qualified to receive services from an IHCP, in accordance with the requirements in Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider*).

4.3.23 Justice Involved Reentry Coordination

Contractor must maintain policies and procedures for coordinating with Correctional Facilities and pre-release care managers in order to support Members who are leaving a Correctional Facility and reentering the community. Such policies and procedures must include all requirements as detailed in the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Initiative, including:

A. A designated Justice Involved liaison, as required in Exhibit A, Attachment III, Subsection 4.3.24 (*Managed Care Liaisons*);

B. Assigning ECM Providers to serve as pre-release care managers and/or as post-release ECM Providers for Justice Involved Individuals;

C. Coordinating the Member's transition from the pre-release to the post-release period, including any needed data sharing; and

D. Ensuring the provision of any Medically Necessary Covered Services including ECM, physical and behavioral health services, Community Supports, NEMT, and Non-Medical Transportation (NMT).

4.3.24 Managed Care Liaisons

Contractor must designate an individual or set of individuals to serve as the day-to-day liaisons for specific services and programs as set forth in the list below to ensure services are closely coordinated with Member's other services and to ensure effective oversight and delivery of services.

Liaisons must receive training on the full spectrum of rules and regulations pertaining to the service they are coordinating, including referral requirements and processes, care management, and authorization processes.

Contractor must notify the other party, for which they are serving as a liaison, of any changes to the liaison as soon as reasonably practical but no later than the date of change and must notify DHCS within five (5) days of the change.

Pursuant to the obligations set forth in this section, Contractor must designate the following liaisons:

A. Tribal liaison as required in Exhibit A, Attachment III, Subsection 4.3.22 (*Indian Health Care Providers*)

B. Long-Term Services and Supports (LTSS) Liaison

LTSS Liaisons must receive training on the rules and regulations pertaining to Medi-Cal covered LTC, including payment and coverage policies; prompt claims payment requirements; Provider resolutions, policies and procedures; and care management, coordination and transition policies.

C. Transportation Liaison

Contractor must have a direct line for Providers and Members to receive real-time assistance directly from Contractor with unresolved transportation issues that can result in missed appointments. The liaison role may not be delegated to a transportation broker. Contractor must also have a process to triage urgent transportation calls when the Member or Provider communicates that they have attempted to work with the broker but the issue remains unresolved and is time sensitive.

D. California Children's Services Liaison

Contractor must have a CCS liaison(s) that serves as the primary point(s) of contact for the coordination of services between Contractor and county CCS Program to ensure the appropriate communication and care coordination are ongoing between the Contractor and county CCS Program, facilitate quarterly meetings,

Back to Agenda Back to Item

and provide updates to the county CCS Program as appropriate. CCS liaison(s) must receive training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical review processes with counties, care management and authorization processes for CCS Children.

E. County Child Welfare Liaison

1) Contractor must designate at least one individual to serve as the county child welfare liaison who will serve as a leader within Contractor to be the point of contact for child welfare departments and be the advocate on behalf of Members involved in county child welfare. Additional county child liaisons must be designated as needed to ensure the needs of Members involved with county child welfare are met.

2) Contractor's county child welfare liaison(s) will follow DHCS-issued standards and expectations as set forth in APLs or other similar instructions. Contractor's county child welfare liaison must:

a) Have expertise in Child welfare services, County Behavioral Health Services.

b) Ensure appropriate ECM staff, including the ECM Lead Care Manager whenever possible, attend meetings of the Child and family teams, in accordance W&I section 16501(a)(4), and ensure Covered services are closely coordinated with other services, including social services and Specialty Mental Health Care Services.

c) Act as a resource to ECM Providers providing services to Child welfare-involved Children and youth, provide technical assistance to Contractor and ECM Provider staff as needed, and serve as a point of escalation for care managers if they face operational obstacles when working with County and community partners.

d) Be sufficiently trained on County Care Coordination and assessment processes.

e) Provide resources and support to Member's care manager about Medi-Cal managed care plan Enrollment and disenrollment when they are made aware that the Member will move to a different county.

Back to Agenda Back to Item

F. Justice Involved Liaison

1) Contractor must have an assigned Justice Involved liaison for justice involved reentry coordination, which may be one individual or multiple identified individuals, and make available information related to the Justice Involved liaison's title, name, contact phone number and email address.

2) The Justice Involved liaison must be available to support Correctional Facilities, pre-release care management Providers, and/or ECM Providers in the reentry planning process as required in Exhibit A, Attachment III, Subsection 4.3.23 (*Justice Involved Reentry Coordination)* and further specified in the Policy and Operational Guide for Planning and Implementing CalAIM Justice Involved Initiative.

G. RC Liaison as required in Exhibit A, Attachment III, Subsection 4.3.15 (*Services for Persons with Developmental Disabilities*)

H. Dental Liaison as required in Exhibit A, Attachment III, Subsection 4.3.17 (*Dental*)

I. IHSS Liaison as required in Exhibit A, Attachment III, Subsection 4.3.21 (*In-Home Support Services*)

Exhibit A, ATTACHMENT III

4.4 Enhanced Care Management

4.4.1 Contractor's Responsibilities for Administration of Enhanced Care Management
4.4.2 Populations of Focus for Enhanced Care Management
4.4.3 Enhanced Care Management Providers
4.4.4 Enhanced Care Management Provider Capacity
4.4.5 Enhanced Care Management Model of Care
4.4.6 Member Identification for Enhanced Care Management
4.4.7 Authorizing Members for Enhanced Care Management
4.4.8 Assignment to an Enhanced Care Management Provider
4.4.9 Initiating Delivery of Enhanced Care Management
4.4.10 Discontinuation of Enhanced Care Management
4.4.11 Core Service Components of Enhanced Care Management
4.4.12 Data System Requirements and Data Sharing to Support Enhanced Care Management
4.4.13 Oversight of Enhanced Care Management Providers
4.4.14 Payment of Enhanced Care Management Providers
4.4.15 Enhanced Care Management Reporting Requirements
4.4.16 Enhanced Care Management Quality and Performance Incentive Program

4.4 Enhanced Care Management

4.4.1 Contractor's Responsibilities for Administration of Enhanced Care Management

A. Contractor must follow all provisions in the Enhanced Care Management (ECM) Policy Guide, in addition to provisions outlined in this Contract.

B. Contractor must take a whole-person approach to offering ECM, ensuring that ECM addresses the clinical and non-clinical needs of high-need and high-cost Members in distinct Populations of Focus, Exhibit A, Attachment III, Subsection 4.4.2 (*Populations of Focus for Enhanced Care Management*), through systematic coordination of services and comprehensive care management.

C. Contractor must ensure ECM is community-based, interdisciplinary, high-touch, and person-centered.

D. Contractor must ensure ECM is available throughout its Service Area.

E. Contractor must ensure ECM is offered primarily through in-person interaction where Members and their family members, legal guardians, Authorized Representatives (ARs), caregivers, and authorized support persons live, seek care, or prefer to access services in their local community. Contractor must ensure its ECM Providers focus on building relationships with Members, and in-person visits may be supplemented with secure teleconferencing and Telehealth, when appropriate and with the Member's consent.

F. In situations where Contractor is performing ECM functions using Contractor's own staff, Contractor must follow the same requirements as an ECM Provider that is a Network Provider or Subcontractor**,** specifically that all such services are community-based, interdisciplinary, high-touch and person-centered. All such situations require DHCS approval through the exemption process and plans must be also making demonstrable progress to moving these ECM functions to community-based providers.

G. Contractor must follow the appropriate processes to ensure Members who may benefit from ECM receive ECM as defined in this Contract.

H. Contractor must ensure ECM provided to each Member encompasses the ECM core service components described in Exhibit A, Attachment III, Subsection 4.4.11 (*Core Service Components of Enhanced Care Management*).

I. Contractor must ensure a Member receiving ECM is not receiving duplicative case management services from other sources, including but not limited to county-specific Targeted Case Management (TCM) services administered by Local Governmental Agencies (LGAs).

J. For Members who are dually eligible for Medicare and Medi-Cal and enrolled in a Medicare Advantage Plan, Contractor must coordinate with the Medicare Advantage Plan for the provision of ECM for those Members.

K. Contractor must develop Member-facing written material about ECM for use across its network of ECM Providers. The written material must be submitted for DHCS review and approval prior to use. This material must include the following, at a minimum:

1) Explain ECM and how a Member may to request it;

2) Maintain a list of ECM Providers as part of its Provider Directory, adherent to requirements established in the ECM Policy Guide;

3) Explain that ECM participation is voluntary and can be discontinued at any time;

4) Explain that the Member must authorize ECM-related data sharing;

5) Describe the process by which the Member may choose a different ECM Lead Care Manager or ECM Provider; and

6) Meet standards for culturally and linguistically appropriate communication Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*) and in Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*).

4.4.2 Populations of Focus for Enhanced Care Management

A. Subject to the phase-in and Member transition requirements described in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management*).

B. Contractor must provide ECM to Members that meet the eligibility criteria for at least one of the following Populations of Focus, as described in the ECM Policy Guide:

1) Members experiencing homelessness:

   a) Members without dependent Children/youth living with them experiencing homelessness; and

   b) Homeless families or unaccompanied Children/youth experiencing homelessness.

2) Members at risk for avoidable hospital or emergency department utilization;

3) Members with serious mental health and/or Substance Use Disorder (SUD) needs;

4) Members transitioning from incarceration;

5) Adult Members living in the community and at risk for Long-Term Care (LTC) institutionalization;

6) A Member residing in an adult nursing facility transitioning to the community;

7) Children enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CCS condition;

8) Children involved in Child welfare; and

9) Birth equity population of focus.

C. Contractor may offer ECM to Members who do not meet Population of Focus criteria in full but may benefit from ECM.

D. Contractor must follow all applicable DHCS policies and guidance, including All Plan Letters (APLs) and the ECM Policy Guide, that further define the approach to ECM for each Population of Focus, including the eligibility criteria for each Population of Focus and the phase-in timeline for Populations of Focus, and the JI Policy and Operations guide, that further define the approach to ECM for the Justice Involved Population of Focus.

E. To avoid duplication between existing care management and coordination approaches, Members are excluded from ECM while enrolled in the following programs:

1) 1915(c) waiver programs including:

   a) Multipurpose Senior Services Program (MSSP);

   b) Assisted Living Waiver (ALW);

   c) Home and Community-Based Alternatives (HCBA) Waiver;

   d) Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver;

   e) HCBS programs for Individuals with Developmental Disabilities (DD); and

   f) Self-Determination Program for Individuals with intellectual and DD.

2) Fully integrated programs for Members dually eligible for Medicare and Medicaid including:

   a) Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs);

   b) Program for All-Inclusive Care for the Elderly (PACE);

   c) Exclusively Aligned Enrollment (EAE) Dual Special Needs Plans (D-SNPs); and

   d) Non EAE D-SNPs.

3) California Community Transitions (CCT) Money Follows the Person (MFTP)

4) Complex Care Management (CCM)

4.4.3 Enhanced Care Management Providers

A. Contractor must ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for the Member, such as where the Member lives, seeks care, or prefers to access services in their local community.

B. ECM Providers may include, but are not limited to, the following entities:

1) Counties;

2) County Behavioral Health Providers;

3) Primary Care Provider (PCP) or Specialist or Physician groups;

4) Federally Qualified Health Centers (FQHCs);

5) Community health centers;

6) Community-based organizations;

7) Hospitals or hospital-based Physician groups or clinics (including public hospitals or district or municipal public hospitals);

8) Rural Health Clinics (RHCs) or Indian Health Care Providers (IHCP);

9) Local Health Departments (LHDs);

10) Behavioral Health entities;

11) Community mental health centers;

12) SUD treatment Providers;

13) Community Health Workers (CHW);

14) Organizations serving individuals experiencing homelessness;

15) Organizations serving justice-involved individuals;

16) CCS Providers; and

17) Other qualified Providers or entities that are not listed above, as approved by DHCS.

C. For the Population of Focus for eligible individuals with Serious Mental Illness (SMI) or SUD and the Population of Focus for eligible individuals with Contractor must prioritize county Behavioral Health staff or Behavioral Health Providers to serve in the ECM Provider role, provided they agree and are able to coordinate all services needed by those Populations of Focus, not just their Behavioral Health Services.

D. Contractor must attempt to contract with each IHCP as set forth in 22 CCR sections 55110 through 55180 to provide ECM, when applicable, as described in Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider*).

E. Contractor must ensure ECM Providers meet the requirements set forth in APLs including but not limited to the requirements regarding the use of a care management documentation system.

F. Care management documentation systems may include certified electronic health record technology, or other documentation tools that can:

1) Document Member goals and goal attainment status;

2) Develop and assign care team tasks;

3) Define and support Member Care Coordination and Care Management needs; and

4) Gather information from other sources to identify Member needs and support care team coordination and communication; and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, LTC facility, housing status).

G. Contractor must also comply with requirements on data exchange pursuant to Exhibit A, Attachment III, Subsection 4.4.12 (*Data System Requirements and Data Sharing to Support Enhanced Care Management*).

H. Contractor must ensure all ECM Providers for whom a State-level Enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 22-013 (Provider Credentialing/Recredentialing and Screening/Enrollment). If APL 22-013 does not apply to an ECM Provider, Contractor must have a process for verifying qualifications and experience of ECM Providers, which must extend to individuals employed by or delivering services on behalf of the ECM Provider. Contractor must ensure that all ECM Providers meet the capabilities and standards required to be an ECM Provider.

I. Contractor must not require eligible ECM Providers to be National Committee for Quality Assurance (NCQA) certified or accredited as a

Back to Agenda Back to Item

condition of entering into a Subcontractor Agreement or Network Provider Agreement, as appropriate.

J. Contractor must ensure ECM Providers serving the Justice Involved Population of Focus meet not only the standard ECM Provider requirements, but requirements outlined in the JI Policy and Operational Guide for Planning and Implementing the Justice Involved Initiative, including, but not limited to:

1) Meeting the following criteria pertaining to participation in pre-release care management services and warm handoffs:

a) If the Correctional Facilities in the ECM Provider's county of operation leverage an in-reach care management model, Contractor must ensure that JI ECM Providers offer pre-release care management services as in-reach care management Providers and continue to serve the Member post-release as the Member's ECM Provider.

b) If the Correctional Facilities in the ECM Provider's county of operation leverage an embedded care management model, Contractor must ensure that the ECM Provider participates in a warm handoff with the pre-release embedded care manager and the Member.

2) ECM Providers must bill Fee-for-Service (FFS) for all pre-release care management services and warm handoffs by either enrolling through the Provider Application and Validation for Enrollment (PAVE) system or contracting with the Correctional Facility to provide services billed under the Correctional Facility National Provider Identifier (NPI).

4.4.4 Enhanced Care Management Provider Capacity

A. Contractor must develop and manage a network of ECM Providers.

B. Contractor must ensure sufficient ECM Provider capacity to meet the unique needs of all ECM Populations of Focus, including by contracting with providers with specific skills and experience serving specific Populations of Focus.

C. Contractor must meet DHCS' requirements regarding ECM Provider capacity separately from general Network adequacy; ECM Provider

capacity does not alter the general Network adequacy provisions in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*).

D. Contractor must report on its ECM Provider capacity to DHCS initially in its ECM Model of Care (MOC) Template as referenced in Exhibit A, Attachment III, Subsection 4.4.*5 (Enhanced Care Management Model of Care)* and on an ongoing basis pursuant to DHCS reporting requirements in a form and manner specified by DHCS.

E. Contractor must report to DHCS any Significant Changes in its ECM Provider capacity as soon as possible but no later than 60 days from the occurrence of the change, in accordance with DHCS reporting requirements in a form and manner specified by DHCS.

F. If Contractor is unable to provide sufficient capacity to meet the needs of all ECM Populations of Focus through Subcontractor or Network Provider Agreements, as appropriate, with community-based ECM Providers, Contractor may submit a written request to DHCS for an exception that authorizes Contractor to use its own personnel for ECM. Any such request must be submitted in accordance with DHCS guidelines and must meet at least one of the following criteria:

1) There are insufficient ECM Providers, or a lack of ECM Providers with qualifications and experience, to provide ECM for one or more of the Populations of Focus in one or more counties;

2) There is a justified Quality of Care concern with one or more of the otherwise qualified ECM Providers;

3) Contractor and the ECM Providers are unable to agree on rates;

4) ECM Providers are unwilling to contract;

5) ECM Providers are unresponsive to multiple attempts to contract;

6) ECM Providers who have a State-level pathway to Medi-Cal Enrollment but are unable to comply with the Medi-Cal Enrollment process or Contractor's verification requirements for ECM Providers; or

7) ECM Providers without a State-level pathway to Medi-Cal Enrollment that are unable to comply with Contractor's verification requirements for ECM Providers.

Back to Agenda Back to Item

G. During an exception period approved by DHCS, Contractor must take steps to continually develop and increase its ECM Network capacity. After the expiration of an exception period, Contractor must submit a new exception request to DHCS for DHCS review and approval on a case-by-case basis.

H. Contractor's failure to provide network capacity that meets the needs of all ECM Populations of Focus in a community-based manner may result in imposition of Corrective Action proceedings, and may result in sanctions pursuant to Exhibit E, Section 1.19 (*Sanctions*).

I. Contractor must ensure Network overlap of the Justice Involved pre-release care management Provider network and the Justice Involved ECM Provider network across Contractor's Service Area. Contractor must submit to DHCS, for prior approval, any requests for exception from Network overlap requirements across Medi-Cal managed care plans in the same county for one of the permissible reasons as described in the JI Policy and Operational Guide for Planning and Implementing the Justice Involved Initiative.

4.4.5 Enhanced Care Management Model of Care

A. Contractor must develop an ECM MOC template in accordance with the DHCS-approved MOC Template. The MOC must specify Contractor's framework for providing ECM, including a listing of its ECM Providers and policies and procedures for partnering with ECM Providers for the provision of ECM.

B. In developing and executing Subcontractor Agreements or Network Provider Agreements, as appropriate, with ECM Providers, Contractor must incorporate all requirements and policies and procedures described in its MOC, in addition to APLs.

C. Contractor may collaborate with other Medi-Cal managed care health plans within the same county on the development of its MOC as applicable for Contractor's plan model.

D. Contractor must submit its ECM MOC for DHCS review and approval. Contractor must also submit to DHCS any Significant Changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs. Significant Changes may include, but are not limited to, changes to Contractor's approach to administering or delivering ECM services, approved policies and procedures, and

Subcontractor Agreement and Downstream Subcontractor Agreement boilerplates.

4.4.6 Member Identification for Enhanced Care Management

A. Contractor must proactively identify Members who may benefit from ECM and who meet the eligibility criteria for the ECM Populations of Focus, as described in Exhibit A, Attachment III, Subsection 4.4.2 (*Populations of Focus for Enhanced Care Management*).

B. To identify such Members, Contractor must consider the following:

1) Members' health care utilization;

2) Needs across physical, behavioral, developmental, and oral health;

3) Health risks and needs due to Social Drivers of Health; and,

4) Long-Term Services and Supports needs.

C. Contractor must identify Members for ECM through the following pathways:

1) Analysis of Contractor's own enrollment, claims, and other relevant data and available information. Contractor must use data analytics to identify Members who may benefit from ECM and who meet the criteria for the ECM Populations of Focus. Contractor must consider data sources, including but not limited to:

a) Enrollment data;

b) Encounter Data;

c) Utilization/claims data;

d) Pharmacy data;

e) Laboratory data;

f) Screening or assessment data;

g) Clinical information on physical and Behavioral Health;

h) SMI/SED/SUD data, if available;

Back to Agenda Back to Item

i) Risk stratification information for Children in County Organized Health System (COHS) counties with WCM programs;

j) Information about Social Drivers of Health, including standardized assessment tools including Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) and International Classification of Diseases, Tenth Revision (ICD-10) codes;

k) Results from any available Adverse Childhood Experience (ACE) screening; and

l) Other cross-sector data and information, including housing, social services, foster care, criminal justice history, and other information relevant to the ECM Populations of Focus (e.g., Homeless Management Information System (HMIS), available data from the education system).

2) Receipt of requests from ECM Providers and other Providers or community-based entities.

a) Contractor must accept requests for ECM on behalf of Members from:

i. ECM Providers;

ii. Social service or other Providers; and

iii. Community-based entities, including those contracted to provide Community Supports, as described in Exhibit A, Attachment III, Subsection 4.5.3 (*Community Supports Providers)*.

b) Contractor must designate an email and dedicated phone number that is widely available by which referrals can be made.

c) Contractor must directly engage with and provide training to Network Providers, Subcontractors, Downstream Subcontractors, and county agencies to inform these entities of ECM, the ECM Populations of Focus, and how to request ECM for Members, with the goal of having the majority of

Back to Agenda Back to Item

ECM eligible Member referrals coming from Providers and community sources, rather than Contractor identification.

d) Contractor must encourage ECM Providers to identify Members who meet the criteria for the ECM Populations of Focus, and must develop a process for receiving and responding to requests from ECM Providers.

3) Requests from Members

a) Contractor must have a process for allowing Members to request ECM and for Members' parents, family members, legal guardians, ARs, caregivers, and authorized support persons to request ECM on a Member's behalf.

b) Contractor must provide information to Members regarding the Member initiated ECM request and approval process.

4) For pre-release services under the Justice Involved Reentry Initiative, Contractor must have processes that:

a) Identify any Member who received pre-release services for presumptive eligibility and enrollment in ECM, including using the JI aid code for enrolled Members.

b) Receive notifications of pre-release services from Correctional Facilities or their contracted pre-release care managers through their JI liaison.

c) Receive notifications from the ECM Provider who is acting as the pre-release care manager or who has received a warm handoff.

4.4.7 Authorizing Members for Enhanced Care Management

A. Contractor must authorize ECM for each eligible Member identified through any of the pathways described in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management*). If a Member meets ECM Population of Focus eligibility requirements, Contractor must authorize ECM without additional requirements.

B. Contractor must develop policies and procedures that explain how it will authorize ECM for eligible Members in an equitable and non-discriminatory manner.

C. For requests from Providers and other external entities, Members, Member's parent, family member, legal guardian, AR, caregiver, or authorized support person:

1) Contractor must ensure that authorization or a decision not to authorize ECM occurs as soon as possible and in accordance with Exhibit A, Attachment III, Subsection 2.3.2 (*Timeframes for Medical Authorization*) and APL 21-011;

2) If Contractor does not authorize ECM, Contractor must ensure the Member and the requesting individual or entity who requested ECM on a Member's behalf, as applicable, are informed of the Member's right to Appeal and the Appeals process by way of the Notice of Action (NOA) process as described in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*), and Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011; and

3) Contractor must follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011.

D. Contractor may collaborate with its ECM Providers to develop a process and identify possible circumstances under which presumptive authorization or preauthorization of ECM may occur, where select ECM Providers may directly authorize ECM for a limited period of time until Contractor authorizes or denies ECM.

E. Contractor must authorize ECM services for all Members who were found eligible for pre-release services under the CalAIM Justice Involved Reentry Initiative. ECM services are authorized for 12 months per the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative.

F. To inform Members that ECM has been authorized , Contractor must follow its standard notice process outlined in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*) and APL 21-011.

4.4.8 Assignment to an Enhanced Care Management Provider

A. Contractor must assign every Member authorized for ECM to an ECM Provider. Contractor may assign Members to Contractor itself only with a DHCS-approved exception to the ECM Provider contracting requirement as described in Exhibit A, Attachment III, Subsection 4.4.4 (*Enhanced Care Management Provider Capacity*).

B. Contractor must develop a process to disseminate information of assigned Members to ECM Providers on a regular basis.

C. Contractor must ensure communication of Member Assignment to the designated ECM Provider occurs within ten Working Days of authorization or on an agreed upon schedule.

D. Pursuant to the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative, for Members eligible for pre-release services under the CalAIM Justice Involved Reentry 1115 Initiative, Contractor must, to the extent possible, assign an ECM Provider that was the pre-release care manager or the care manager who received a warm handoff from the Correctional Facility while the individual was incarcerated.

E. If a Member prefers a specific ECM Provider, Contractor must assign the Member to that Provider, to the extent practicable.

F. If a Member's assigned PCP is a contracted ECM Provider, Contractor must assign the Member to the PCP as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

G. If a Member receives services from a MHP for SED, SUD, or SMI and the Member's Behavioral Health Provider is a contracted ECM Provider, Contractor must assign that Member to that Behavioral Health Provider as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

H. If a Member is enrolled in CCS and the Member's CCS Case Manager is Affiliated with a contracted ECM Provider, Contractor must assign that Member to that CCS Case Manager as the ECM Provider, unless the Member or parent, legal guardian, or AR has indicated otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

I. Contractor must notify the Member's PCP, if different from the ECM Provider, of the assignment to the ECM Provider, within ten Working Days of the date of assignment.

J. Contractor must document the Member's ECM Lead Care Manager in its system of record.

K. Contractor must permit Members to change ECM Providers at any time. Contractor must implement any Member's request to change their ECM Provider within 30 calendar days to the extent practicable.

4.4.9 Initiating Delivery of Enhanced Care Management

A. Contractor must not require Member authorization for ECM-related data sharing (whether in writing or otherwise) as a condition of initiating delivery of ECM, unless such authorization is required by federal law.

B. Contractor must develop policies and procedures for its network of ECM Providers that meet the following requirements, including but not limited to:

1) Where required by law, ECM Providers must obtain Member's authorization to share information with Contractor and all others involved in the Member's care to maximize the benefits of ECM; and

2) ECM Providers must provide Contractor with Member-level records of any obtained authorizations for ECM-related data sharing as required by federal law and to facilitate ongoing data sharing with Contractor.

C. Contractor must ensure that upon the initiation of ECM, each Member receiving ECM has an ECM Lead Care Manager with responsibility for interacting directly with the Member and the Member's family, legal guardians, ARs, caregivers, and other authorized support persons, as appropriate.

The assigned ECM Lead Care Manager is responsible for engaging with a multi-disciplinary care team to identify any gaps in the Member's care and, at a minimum, ensure effective coordination of all physical health care, behavioral, developmental, oral health, LTSS, Community Supports, and other services to address Social Drivers of Health, regardless of setting.

D. Contractor must ensure accurate and up-to-date Member-level records related to the provision of ECM services are maintained for Members authorized for ECM.

4.4.10 Discontinuation of Enhanced Care Management

A. Contractor must ensure Members are able to decline or end ECM upon initial outreach and engagement, or at any other time.

B. Contractor must require the ECM Provider to notify Contractor to discontinue ECM for Members when any of the following circumstances are met:

1) The Member has met all care plan goals;

2) The Member is ready to transition to a lower level of care;

3) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; or

4) The ECM Provider has not been able to connect with the Member after multiple attempts.

C. Contractor must develop processes to determine if the Member is no longer authorized to receive ECM and, if so, to notify the ECM Provider to initiate discontinuation of services in accordance with the NOA process described in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*); Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*); and APL 21-011.

D. Contractor must develop processes for transitioning Members from ECM to other levels of care management to provide coordination of ongoing Member needs.

E. Contractor must notify the ECM Provider when ECM has been discontinued by Contractor.

F. Contractor must notify the Member of the discontinuation of the ECM benefit and ensure the Member is informed of their right to Appeal and the Appeals process by way of the NOA process as described in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*), and Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011.

4.4.11 Core Service Components of Enhanced Care Management

Contractor must ensure all Members receive all of the following seven ECM core service components, as further defined in APLs:

A. Outreach and engagement;

B. Comprehensive assessment and Care Management Plan (CMP);

C. Enhanced coordination of care;

D. Health promotion;

E. Comprehensive transitional care;

F. Member and family supports; and

G. Coordination of and referral to community and social support services.

4.4.12 Data System Requirements and Data Sharing to Support Enhanced Care Management

A. Contractor must have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to:

1) Consume and use claims and Encounter Data, as well as other data types listed in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management*);

2) Assign Members to ECM Providers;

3) Keep records of Members receiving ECM and authorizations necessary for sharing PHI and PI between Contractor and ECM and other Providers, among ECM Providers and family member(s) and/or support person(s), whether obtained by ECM Provider or by Contractor;

4) Securely share data with ECM Providers and other Providers in support of ECM;

5) Receive, process, and send Encounter Data from ECM Providers to DHCS;

6) Receive and process supplemental reports from ECM Providers;

7) Send ECM supplemental reports to DHCS; and

8) Open, track, and manage referrals to Community Supports Providers.

B. To support ECM, Contractor must follow DHCS guidance on data sharing and provide the following information to all ECM Providers:

1) Member Assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;

2) Encounter Data and claims data;

3) Physical, behavioral, administrative, and Social Drivers of Health data (e.g., HMIS data) for all Members assigned to the ECM Provider; and

4) Reports of performance on quality measures and metrics, as requested.

C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ECM Providers and with DHCS in compliance with data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework, in accordance with H&S section 130290.

4.4.13 Oversight of Enhanced Care Management Providers

A. Contractor must perform oversight of ECM Providers, holding them accountable to all ECM requirements contained in this Contract, DHCS policies and guidance, APLs, and Contractor's MOC.

1) Contractor must evaluate the prospective Subcontractor's and Downstream Subcontractor's ability to perform services as described in Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*);

2) Contractor must ensure the Subcontractor's and Downstream Subcontractor's capacity is sufficient to serve all Populations of Focus;

Back to Agenda Back to Item

3) Contractor must report to DHCS the names of all Subcontractors, Network Providers, and Downstream Subcontractors by Subcontractor and Downstream Subcontractor type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan*); and

4) Contractor must make all Subcontractor Agreements or Network Provider Agreements, as appropriate, available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment III, Subsection 3.1.5.B (*Subcontractor and Downstream Subcontractor Agreement Requirements*).

B. Contractor may hold ECM Providers responsible for the same reporting requirements as those Contractor has with DHCS to support data collection and reporting.

1) Contractor must not impose mandatory reporting requirements that differ from or are additional to those required for Encounter and supplemental reporting; and

2) Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on oversight of ECM Providers.

C. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of ECM Providers, unless by mutual consent with the ECM Provider.

D. Contractor must provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars, or calls, as necessary, in addition to Network Provider training requirements, as applicable, described in Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training).*

E. Contractor must ensure the Subcontractor Agreement and Downstream Subcontractor Agreement mirrors the requirements set forth in this Contract and in accordance with APLs, as applicable to Subcontractor.

Contractor may collaborate with its Subcontractors and Downstream Subcontractors on the approach to administration of ECM to minimize divergence in how ECM will be implemented between Contractor and its Subcontractors and Downstream Subcontractors, and to ensure a streamlined, seamless experience for ECM Providers and Members.

4.4.14 Payment of Enhanced Care Management Providers

A. Contractor must pay ECM Providers for the provision of ECM in accordance with Subcontractor Agreements or Network Provider Agreements established between Contractor and each ECM Provider.

B. Contractor must ensure that ECM Providers are eligible to receive payment when ECM is initiated for any given Member, as described in Exhibit A, Attachment III, Subsection 4.4.9 (*Initiating Delivery of Enhanced Care Management*).

C. Contractor may tie ECM Provider payments to value, including payment strategies and arrangements that focus on achieving outcomes related to high-quality care and improved health status.

D. Contractor must utilize the claims timeline as described in Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*).

4.4.15 Enhanced Care Management Reporting Requirements

A. Contractor must submit the following data and reports to DHCS to support DHCS' oversight of ECM:

1) Encounter Data:

a) Contractor must submit all ECM Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS.

b) Contractor must submit to DHCS all Encounter Data for ECM services to its Members, regardless of the number of levels of delegation and/or sub-delegation between Contractor and the ECM Provider.

c) In the event the ECM Provider is unable to submit ECM Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor is responsible for converting the ECM Provider's

Back to Agenda Back to Item

Encounter Data information into the national standard specifications and code sets, for submission to DHCS.

2) ECM supplemental reports, on a schedule and in a format to be defined by DHCS.

B. Contractor must track and report to DHCS, on a schedule and in a format specified by DHCS, information about outreach efforts related to Potential Members to be enrolled in ECM.

C. In the event of underperformance by Contractor in relation to its administration of ECM, DHCS may impose sanctions as described in Exhibit E, Section 1.19 (*Sanctions*).

4.4.16 Enhanced Care Management Quality and Performance Incentive Program

A. Contractor must meet all quality management and Quality Improvement requirements in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program (QIHETP)*) and any additional quality requirements set forth in associated guidance from DHCS for ECM.

B. Contractor may participate in a performance incentive program related to building Provider capacity for ECM, related health care quality and outcomes, and other performance milestones and measures, in accordance with APL 23-003 or other technical guidance.

Exhibit A, ATTACHMENT III

4.5 Community Supports

4.5.1 Contractor's Responsibility for Administration of Community Supports
4.5.2 DHCS Pre-Approved Community Supports
4.5.3 Community Supports Providers
4.5.4 Community Supports Provider Capacity
4.5.5 Community Supports Model of Care
4.5.6 Identifying Members for Community Supports
4.5.7 Authorizing Members for Community Supports and Communication of Authorization Status
4.5.8 Referring Members to Community Supports Providers for Community Supports
4.5.9 Data System Requirements and Data Sharing to Support Community Supports
4.5.10 Contractor's Oversight of Community Supports Providers
4.5.11 Delegation of Community Supports Administration to Network Providers, Subcontractors, or Downstream Subcontractors
4.5.12 Payment of Community Supports Providers
4.5.13 Community Supports Reporting Requirements
4.5.14 Community Supports Quality and Performance Incentive Program

4.5 Community Supports

For the purposes of this Section 4.5 (*Community Supports*), "California Medicaid State Plan Covered Service or Setting" means any health service or care environment approved and funded under the California Medicaid State Plan, such as inpatient services, nursing facilities, or home health care.

4.5.1 Contractor's Responsibility for Administration of Community Supports

A. Contractor may provide DHCS pre-approved Community Supports as described in Exhibit A, Attachment III, Subsection 4.5.2 (*DHCS Pre-Approved Community Supports*).

This Section (Section 4.5) refers only to Community Supports that Contractor may choose to offer, unless otherwise specified.

B. In accordance with 42 Code of ederal Regulations (CFR) section 438.3(e)(2), and the Member rights and protections defined within, all applicable All Plan Letters (APLs), and the Community Supports Policy Guide, Contractor may select and offer Community Supports from the list of Community Supports pre-approved by DHCS as medically appropriate and cost-effective substitutes for Covered Services or settings under the California Medicaid State Plan. See Exhibit A, Attachment III, Subsection 4.5.2 (*DHCS Pre-Approved Community Supports*) below for the list.

1) Contractor must ensure medically appropriate California Medicaid State Plan services are available to the Member regardless of whether the Member has been offered Community Supports, is currently receiving Community Supports, or has received Community Supports in the past.

2) Contractor must not require a Member to utilize Community Supports. Members always retain their right to receive the California Medicaid State Plan services on the same terms as would apply if Community Supports was not an option in accordance with regulatory requirements.

3) Contractor must not use Community Supports to reduce, discourage, or jeopardize Members' access to California Medicaid State Plan services.

4) Contractor may submit a request to DHCS to offer Community Supports in addition to the pre-approved Community Supports.

C. With respect to pre-approved Community Supports, Contractor must adhere to DHCS guidance on service definitions, eligible populations, code sets, potential Community Supports Providers, and parameters for each Community Support that Contractor chooses to provide, as referenced in APL 21-017 and the Community Supports Policy Guide.

1) Contractor is not permitted to extend Community Supports to Members beyond those for whom DHCS has determined the Community Supports will be cost-effective and medically appropriate.

2) Contractor may not adopt a more narrowly defined eligible population for Community Supports than outlined in Exhibit A, Attachment III, Subsection 4.5.2 (*DHCS Pre-Approved Community Supports*). That Subsection details (i) the name and definition of each Community Support; (ii) the Covered Services or settings under the California Medicaid State Plan that each Community Support may replace; (iii) the target populations for each Community Support; (iv) Member rights and protections; and (v) the requirement to use State-designated codes in Encounter Data for each Community Support.

D. If Contractor elects to offer one or more pre-approved Community Supports, it need not offer the Community Supports in each county it serves. Contractor must report to DHCS the counties in which it intends to offer the Community Supports. Contractor must provide Community Supports in a county selected by Contractor in accordance with the requirements set forth in Exhibit A, Attachment III, Subsection 4.5.4 (*Community Supports Provider Capacity*).

E. Contractor must identify Members for whom Community Supports will be a medically appropriate alternative to Covered Services, and accept requests for Community Supports from Members and Members' Providers and organizations that serve them, including community-based organizations as described in Exhibit A, Attachment III, Subsection 4.5.6 (*Identifying Members for Community Supports*).

F. Contractor must authorize Community Supports for Members deemed eligible in accordance with Exhibit A, Attachment III, Subsection 4.5.7 (*Authorizing Members for Community Supports and Communication of Authorization Status*).

G. Contractor may elect to offer value-added services in addition to offering one or more Community Supports. Offering or not offering Community

Back to Agenda Back to Item

Supports does not preclude Contractor from offering value-added services.

H. In the event of any discontinuation of Community Supports resulting in a change in the availability of services, Contractor must adhere to the requirements set forth in Exhibit A, Attachment III, Subsection 5.2.9 (*Network and Access Changes to Covered Services*).

I. When Members are dually eligible for Medicare and Medi-Cal, and enrolled in a Medicare Advantage Plan, including a Dual Special Needs Plan (D-SNP), Contractor must coordinate with the Medicare Advantage Plan in the provision of Community Supports.

J. Contractor must not require Members to use Community Supports.

4.5.2 DHCS Pre-Approved Community Supports

A. Contractor may choose to offer Members one or more of the following pre-approved Community Supports, and any subsequent Community Supports additions pre-approved by DHCS, in each county.

1) Housing transition navigation services

a. Housing transition navigation services assist Members with obtaining housing through supports such as a housing assessment, individualized planning, application assistance, and landlord engagement.

b. Members must meet at least one of the following sets of eligibility criteria (i, ii, or iii):

i. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless coordinated entry system or similar system designed to use information to identify highly vulnerable individuals who meet at least one of the following sets of criteria (a, b, c, d, or e):

a. Have disabilities;

b. Have one or more serious chronic conditions;

c. Have a Serious Mental Illness (SMI);

Back to Agenda Back to Item

d. Are at risk of institutionalization or requiring residential services because of a Substance Use Disorder (SUD); or

e. Are exiting incarceration.

ii. Members who meet the United States Department of Housing and Urban Development (HUD) definition of "homeless" as defined in 24 CFR section 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and who meet at least one of the following sets of criteria (a, b, c, or d):

a. Are receiving Enhanced Care Management (ECM);

b. Have one or more serious chronic conditions;

c. Have a SMI; or

d. Are at risk of institutionalization or requiring residential services as a result of a SUD. Qualifying institutions include hospitals, Correctional Facilities, mental health residential treatment facilities, SUD residential treatment facilities, recovery residences, Institutions for Mental Diseases (IMD), and state hospitals.

iii. Members who meet the HUD definition of "at risk of homelessness" as defined in 24 CFR section 91.5 and have significant barriers to housing stability and meet at least one of the following sets of criteria (a, b, c, d, e, or f):

a. Are receiving ECM;

b. Have one or more serious chronic conditions;

c. Have a SMI;

d. Are at risk of institutionalization or overdose or are requiring residential services because of a SUD;

e. Have a Serious Emotional Disturbance (SED) (children and adolescents); or

f. Are a transition-age Youth (aged 16 to 25 years) with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, having a SMI, having a SED, or having been a victim of trafficking or domestic violence.

c) Housing transition navigation services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Housing transition navigation services may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, emergency transport services, inpatient services, outpatient hospital services, outpatient mental health, rehabilitation center outpatient services, Skilled Nursing Facility (SNF) services, and transitional inpatient care services.

d) Contractor must document the Encounter for the housing transition navigation services rendered using the standard Healthcare Common Procedure Coding System (HCPCS) code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

2) Housing deposits

a) Housing deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a Member to establish a basic household that do not constitute room and board, such as first and last month's rent as required by a landlord for occupancy, security deposits, utility set up fees/deposits, or service access and utility arrearages. Housing deposits are available once per California Advancing and Innovating

Medi-Cal (CalAIM) demonstration period. Once a Member is determined eligible for and authorized for housing deposits, they are authorized to receive the service at any time during a 12-month period from when authorization occurs.

b) Members must meet at least one of the following sets of eligibility criteria (i, ii, or iii):

i. Members who received the housing transition navigation services Community Support in counties that offer housing transition navigation services;

a. While all Members who receive housing transition navigation services are eligible for housing deposits, Contractor must not require that Members receive housing transition navigation services to be eligible for housing deposits.

ii. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless coordinated entry system or similar system designed to use information to identify highly vulnerable individuals who meet at least one of the following sets of criteria (a, b, c, d, or e):

a. Have disabilities;

b. Have one or more serious chronic conditions;

c. Have a SMI;

d. Are at risk of institutionalization or requiring residential services because of a SUD;

e. Are exiting incarceration.

iii. Members who meet the HUD definition of “homeless” as defined in 24 CFR section 91.5 (including those exiting institutions but not including any limits on the

number of days in the institution) and meet at least one of the following sets of criteria (a, b, c, or d):

a. Are receiving ECM;

b. Have one or more serious chronic conditions;

c. Have a SMI; or

d. Are at risk of institutionalization or requiring residential services as a result of a SUD. Qualifying institutions include hospitals, Correctional Facilities, mental health residential treatment facilities, SUD residential treatment facilities, recovery residences, IMDs, and state hospitals.

c) Housing deposits may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Housing deposits may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, emergency transport services, inpatient services, outpatient hospital services, outpatient mental health, rehabilitation center outpatient services, SNF services, and transitional inpatient care services.

d) Contractor must document the Encounter for housing deposit services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

3) Housing tenancy and sustaining services

a) Housing tenancy and sustaining services provide support to Members in maintaining a safe and stable tenancy once housing is secured. Support may include education on tenant and landlord rights and responsibilities, reducing the risk of eviction, coordinating updates to housing support and

crisis plans, and assistance with lease compliance. Services are available for a single duration in the Member's lifetime.

b) Members must meet at least one of the following sets of eligibility criteria (i, ii, iii, or iv):

i. Any Member who received the housing transition navigation services Community Support in counties that offer housing transition navigation services;

a. While all Members who receive housing transition navigation services are eligible for housing tenancy and sustaining services, Contractor must not require that Members receive housing transition navigation services to be eligible for housing tenancy and sustaining services.

ii. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless coordinated entry system or similar system designed to use information to identify highly vulnerable individuals who meet at least one of the following sets of criteria (a, b, c, d, or, e):

a. Have disabilities;

b. Have one or more serious chronic conditions;

c. Have a SMI;

d. Are at risk of institutionalization or requiring residential services because of a SUD; or

e. Are exiting incarceration.

iii. Members who meet the HUD definition of "homeless" as defined in of 24 CFR section 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet at least one of the following sets of criteria (a, b, c, or d):

a. Are receiving ECM;

b. Have one or more serious chronic conditions;

c. Have a SMI; or

d. Are at risk of institutionalization or requiring residential services as a result of a SUD. Qualifying institutions include hospitals, Correctional Facilities, mental health residential treatment facilities, SUD residential treatment facilities, recovery residences, IMDs, and state hospitals.

iv. Members who meet the HUD definition of "at risk of homelessness" as defined in 24 CFR section 91.5, have significant barriers to housing stability, and meet at least one of the following sets of criteria (a, b, c, d, e, or f):

a. Have one or more serious chronic conditions;

b. Have a SMI;

c. Are at risk of institutionalization or overdose or are requiring residential services because of a SUD;

d. Have a SED (Children and adolescents);

e. Are receiving ECM; or

f. Are a transition-age Youth (aged 16 to 24 years) with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, having a SMI, having a SED, or having been a victim of trafficking or domestic violence.

c) Housing tenancy and sustaining services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Housing tenancy and sustaining services may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department

visit, emergency transport services, inpatient services, outpatient hospital services, outpatient mental health, rehabilitation center outpatient services, and transitional inpatient care services.

d) Contractor must document the Encounter for the housing tenancy and sustaining services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

4) Short-term post-hospitalization housing

a) Short-term post-hospitalization housing provides Members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical, psychiatric, or SUD recovery immediately after exiting an inpatient acute, psychiatric, or chemical dependency and recovery hospital; residential SUD treatment or recovery facility; residential mental health treatment facility; correctional facility; nursing facility; or recuperative care and to avoid utilization of California Medicaid State Plan covered services or settings. Short-term post-hospitalization services are available once in a Member's lifetime and are not to exceed a duration of six months.

b) To receive short-term post-hospitalization services, Members must have medical or behavioral health needs such that experiencing homelessness upon discharge from an inpatient acute, psychiatric, or chemical dependency and recovery hospital; residential SUD treatment or recovery facility; residential mental health treatment facility; correctional facility; nursing facility; or recuperative care would likely result in Emergency Department utilization, hospitalization, or institutional admission. Members must also meet at least one of the following sets of eligibility criteria (i or ii):

i. Members exiting recuperative care; or

Back to Agenda Back to Item

ii. Members exiting an inpatient acute, psychiatric, or chemical dependency and recovery hospital stay; residential SUD treatment or recovery facility; residential mental health treatment facility; correctional facility; or nursing facility and who meet at least one of the following sets of criteria (a or b):

a. Members who meet the HUD definition of "homeless" as defined in 24 CFR section 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet at least one of the following sets of criteria (1, 2, 3, or 4). If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization. The timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless to thirty (30) days:

1. Are receiving ECM;

2. Have one or more serious chronic conditions; or

3. Have a SMI; or

4. Are at risk of institutionalization or requiring residential services as a result of a SUD. Qualifying institutions include hospitals, Correctional Facilities, mental health residential treatment facilities, SUD residential treatment facilities, recovery residences, IMDs, and state hospitals.

b. Members who meet the HUD definition of "at risk of homelessness" as defined in 24 CFR section 91.5, have significant barriers to

housing stability, and meet at least one of the following sets of criteria (1, 2, 3, 4, 5, or 6):

1. Have one or more serious chronic conditions;

2. Have a SMI;

3. Are at risk of institutionalization or overdose or are requiring residential services because of a SUD;

4. Have a SED (Children and adolescents);

5. Are receiving ECM; or

6. Are a transition-age Youth (aged 16 to 24 years) with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, having a SMI, having a SED, and/or having been a victim of trafficking or domestic violence.

c) Short-term post-hospitalization housing services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Short-term post-hospitalization housing services may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, emergency transport services, inpatient services, outpatient hospital services, post-acute care, and SNF services.

d) Contractor must document the Encounter for the short-term post-hospitalization housing services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at

Back to Agenda Back to Item

https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

5) Recuperative care (medical respite)

a) Recuperative care, also referred to as medical respite care, is short-term residential care for Members who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. Recuperative care or medical respite care is allowable for no more than 90 days in continuous duration. This support does not include funding for building modification or building rehabilitation.

b) Members must meet at least one of the following sets of eligibility criteria (i, ii, iii, iv, or v):

i. Members who are at risk of hospitalization or are post-hospitalization;

ii. Members who live alone with no formal supports;

iii. Members who face housing insecurity or have housing that would jeopardize their health and safety without modification;

iv. Members who meet the HUD definition of “homeless” as defined in 24 CFR section 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet at least one of the following sets of criteria (1, 2, 3, or 4). If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization. The timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless to thirty (30) days:

1. Are receiving ECM;

2. Have one or more serious chronic conditions;

3. Have a SMI; or

4. Are at risk of institutionalization or requiring residential services as a result of a SUD. Qualifying institutions include hospitals, Correctional Facilities, mental health residential treatment facilities, SUD residential treatment facilities, recovery residences, IMDs, and state hospitals.

v. Members who meet the HUD definition of "at risk of homelessness" as defined in 24 CFR section 91.5, have significant barriers to housing stability, and meet at least one of the following sets of criteria (1, 2, 3, 4, 5, 6, or 7):

1. Have one or more serious chronic conditions;

2. Have a SMI;

3. Are at risk of institutionalization or overdose or are requiring residential services because of a SUD;

4. Have a SED (Children and adolescents);

5. Are receiving ECM;

6. Are a transition-age Youth (aged 16 to 24 years) with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, having a SMI, having a SED, or having been a victim of trafficking or domestic violence; or

7. Are able to transition out of inpatient facility care, SNF care, or other health care facility, and recuperative care is medically appropriate and cost-effective.

c) Recuperative care or medical respite care may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer

Back to Agenda Back to Item

timeframe. Recuperative care or medical respite care may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, emergency transport services, inpatient services, outpatient hospital services, post-acute care, and SNF services.

d) Contractor must document the Encounter for the recuperative care or medical respite care rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

6) Respite services

a) Respite services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those Members who normally care for or supervise them and are non-medical in nature. Respite services may attend to the Member's basic self-help needs and other Activities of Daily Living (ADL). In the home setting, these services, in combination with any direct care services the Member is receiving, may not exceed 24 hours per day of care. The service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Contractor can authorize exceptions to the 336 hour per calendar year limit when the caregiver experiences an episode, including medical treatment and hospitalization, that leaves a Member without their caregiver.

b) Members must meet at least one of the following eligibility criteria (i, ii, iii, iv, or v):

i. Members who live in the community and are compromised in their ADLs and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement;

ii. Children who previously were covered for respite services under the pediatrics palliative care waiver;

iii. Foster care program beneficiaries;

iv. Members enrolled in either CCS or the Genetically Handicapped Persons Program (GHPP); or

v. Members with Complex Care Needs, which means the multifaceted health and social support requirements of Members who face significant barriers to achieving and maintaining health and stability. This includes individuals with multiple chronic conditions, functional impairments, behavioral health challenges, or those requiring extensive care coordination due to social determinants of health.

c) Respite services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Respite services may potentially substitute the following California Medicaid State Plan covered services or settings: home health agency, home health aide, Intermediate Care Facility (ICF) services, ICF services for the developmentally disabled, ICF services for the developmentally disabled - habilitative, personal care services, SNF stay, and specialized rehabilitative services in SNFs and ICFs.

d) Contractor must document the Encounter for the respite services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

7) Day habilitation programs

a) Day habilitation programs are provided in a Member's home or an out-of-home, non-facility setting. The programs are designed to assist the Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the Member's natural environment. These services include the use of public transportation and daily living skills (cooking, cleaning, shopping, and money management).

b) Members must meet at least one of the following eligibility criteria (i, ii, or iii):

i. Members who are experiencing homelessness;

ii. Members who exited homelessness and entered housing in the last 24 months; or

iii. Members at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

c) Day habilitation programs may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Day habilitation programs may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, occupational therapy, outpatient hospital services, outpatient mental health, rehabilitation center outpatient services, and targeted case management services.

d) Contractor must document the Encounter for the day habilitation program services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

8) Nursing facility transition / diversion to assisted living facilities

a) Nursing facility transition / diversion services assist Members in transitioning to and living in an assisted living facility and in avoiding institutionalization when possible. These services may include assessing a Member's housing needs and presenting options, assisting in securing a facility residence, assessing the service needs of the Member to determine if the Member needs enhanced services onsite, and coordinating their move. These services also include ongoing assisted living services, such as support with ADLs and Instrumental ADLs (IADLs) as needed, companion services, and mediation oversight, that can be delivered up to 24 hours through direct care staff to meet unpredictable

Back to Agenda Back to Item

needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security.

b) Members must meet at least one of the following eligibility criteria (i or ii):

i. For nursing facility transition:

a. Have resided 60 or more days in a nursing facility;

b. Are willing to live in an assisted living setting as an alternative to a nursing facility; and

c. Are able to reside safely in an assisted living facility with appropriate and cost- effective supports.

ii. For nursing facility diversion:

a. Are interested in remaining in the community;

b. Are willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and

c. Are currently receiving Medically Necessary nursing facility level of care or meet the minimum criteria to receive nursing facility level of care services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility level of care services at an assisted living facility.

c) Nursing facility transition / diversion services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Nursing facility transition / diversion services may potentially substitute the following California Medicaid State Plan services or settings: emergency department visit, inpatient services, ICF services, ICF services for the developmentally disabled, ICF services for the

developmentally disabled - habilitative, SNF stay, and specialized rehabilitative services in SNFs and ICFs.

d) Contractor must document the Encounter for the nursing facility transition / diversion services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

9) Community transition services / nursing facility transition to a home

a) Community transition services / nursing facility transition to a home services support Members with transitional care coordination from a licensed facility to a living arrangement in a private residence where the Member is directly responsible for their own living expenses. This service also covers set-up expenses necessary for a Member to establish a basic household, such as security deposits and utility set-up fees. Non-recurring set-up expenses are payable up to a total lifetime maximum amount of $7,500. The transitional coordination cost is excluded from this total lifetime maximum. These services do not include monthly rental or mortgage expenses, food, regular utility charges, or household appliances or items that are intended for purely diversionary or recreational purposes.

b) Members must meet all of the following sets of eligibility criteria (i, ii, iii, and iv):

i. Are currently receiving medically necessary nursing facility level of care services and, in lieu of remaining in the nursing facility or medical respite setting, is choosing to transition home and continue to receive medically necessary nursing facility level of care services;

ii. Has lived 60+ days in a nursing home and/or medical respite setting;

iii. Are interested in moving back to the community; and

iv. Are able to reside safely in the community with appropriate and cost-effective supports and services.

c) Community transition services / nursing facility transition to a home services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Community transition services / nursing facility transition to a home services may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, inpatient services, ICF services, ICF services for the developmentally disabled, ICF services for the developmentally disabled - habilitative, ICF services for the developmentally disabled - nursing, SNF stay, specialized rehabilitative services in SNFs and ICFs.

d) Contractor must document the Encounter for the community transition services / nursing facility transition to a home services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

10) Personal care and homemaker services

a) Personal care and homemaker services are for Members who need assistance with ADLs such as bathing, dressing, toileting, ambulation, or feeding. Personal care and homemaker services can also include assistance with IADLs, such as meal preparation, grocery shopping, and money management. Contractor cannot utilize these services in lieu of referring to the In-Home Supportive Services (IHSS) program. Contractor must refer Members to the IHSS program when they meet referral criteria.

b) Members must meet at least one of the following sets of eligibility criteria (i, ii, or iii):

i. Members at risk for hospitalization, or institutionalization in a nursing facility;

ii. Members with functional deficits and no other adequate support system; or

iii. Members approved for IHSS. IHSS eligibility criteria can be found at:

http://www.cdss.ca.gov/In-Home-Supportive-Services.

c) Personal care and homemaker services may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Personal care and homemaker services may potentially substitute the following California Medicaid State Plan covered services or settings: home health agency services, home health aide services, inpatient services, ICF services, ICF services for the developmentally disabled, ICF services for the developmentally disabled - habilitative, SNF stay, and specialized rehabilitative services in SNFs and ICFs.

d) Contractor must document the Encounter for the personal care and homemaker services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

11) Environmental accessibility adaptations

a) Environmental accessibility adaptations are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the Member, or enable the Member to function with greater independence in the home, without which the Member would require institutionalization. These services include ramps and grab-bars to assist Members in accessing the home and doorway widening for Members who require a wheelchair.

b) Environmental accessibility adaptations are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if:

i. The Member’s place of residence changes; or

ii. The Member’s condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater

independence in the home and avoid institutionalization or hospitalization.

c) Members at risk for institutionalization in a nursing facility are eligible for environmental accessibility adaptations.

d) Environmental accessibility adaptations may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Environmental accessibility adaptions may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, home health agency services, home health aide services, inpatient services, ICF services, ICF services for the developmentally disabled, ICF services for the developmentally disabled - habilitative, personal care services, SNF stay, and specialized rehabilitative services in SNFs and ICFs.

e) Contractor must document the Encounter for the environmental accessibility adaptations rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

12) Medically tailored meals / medically supportive food

a) Medically tailored meals / medically supportive foods are nutrition interventions to improve the health outcomes of Members. In addition to medically tailored meals, these services may also include medically tailored groceries, food pharmacies, or health food vouchers when paired with nutrition education for Members. Members can receive up to two meals per day and may be authorized for up to 12 weeks and may be reauthorized thereafter if Medically Necessary.

b) To be eligible for medically tailored meals / medically supportive foods, Members must have chronic or other serious health conditions, such as, but not limited to, diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, Human Immunodeficiency Virus (HIV), cancer, gestational diabetes or other high risk

Back to Agenda Back to Item

perinatal conditions, and chronic or disabling mental or behavioral health disorders.

c) Medically tailored meals / medically supportive foods may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Medically tailored meals / medically supportive foods may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, emergency transport services, home health agency services, home health aide services, inpatient services, outpatient hospital services, and personal care services.

d) Contractor must document the Encounter for the medically tailored meals / medically supportive food services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

13) Sobering centers

a) Sobering centers are alternative destinations for Members who are found to be publicly intoxicated (due to alcohol or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these Members with a safe, supportive environment to become sober and receive support such as rehydration and food service and treatment for nausea. This service is covered for a duration of less than 24 hours.

b) Members must meet all of the following sets of eligibility criteria (i, ii, and iii):

i) Are age 18 or older;

ii) Are intoxicated but conscious, cooperative, able to walk, are nonviolent, and free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms); and

iii) Who would otherwise be transported to the emergency department or a jail, or who presented at

Back to Agenda Back to Item

an emergency department and are appropriate to be diverted to a sobering center.

c) Sobering centers may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Sobering centers may potentially substitute the following California Medicaid State Plan covered services or settings: emergency department services, inpatient services, and emergency transport services.

d) Contractor must document the Encounter for the sobering center services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

14) Asthma remediation

a) Asthma remediation services are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of Members, or enable Members to function in the home, and without which acute asthma episodes could result in the need for emergency services and hospitalization. These services include minor mold removal and remediation services, ventilation improvements, and allergen impermeable mattresses and pillow dustcovers.

b) Asthma remediation services are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum is if the Member's condition has changed so significantly that additional modifications:

i) Are necessary to ensure the health, welfare, and safety of the Member; or

ii) Are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

c) Eligible Members are those with poorly controlled asthma (as determined by an emergency department visit or hospitalization, two sick or urgent care visits in the past 12 months, or a score of 19 or lower on the asthma control test)

for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

d) Asthma remediation may serve as an immediate alternative to a California Medicaid State Plan covered service or setting, or as a replacement over a longer timeframe. Asthma remediation may potentially substitute the following California Medicaid State Plan covered services or settings: asthma-related Primary Care and specialty visits, emergency department services, home health aide, home health agency, inpatient stay, outpatient hospital services, and personal care services.

e) Contractor must document the Encounter for the asthma remediation services rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

B. Contractor must list all Community Supports it offers in its Community Supports Model of Care (MOC) template and Community Supports MOC amendments.

C. Contractor must ensure Community Supports are provided in accordance with APLs and DHCS' Community Supports Policy Guide.

D. Contractor must ensure Community Supports are provided to Members in a timely manner, and must develop policies and procedures outlining its approach to managing Community Supports Provider shortages or other barriers to ensure timely provision of Community Supports.

E. Contractor may discontinue offering Community Supports annually with notice to DHCS at least 90 calendar days prior to the discontinuation date.

Contractor must ensure Community Supports that were authorized for a Member prior to the discontinuation of those specific Community Supports are not disrupted by a change in Community Supports offerings, either by completing the authorized service or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet the Member's needs.

F. At least 30 calendar days before discontinuing one or more Community Supports, Contractor must notify impacted Members of the following:

1) The change and timing of discontinuation, and

2) The procedures that will be used to ensure completion of the authorized Community Supports or a transition into other comparable Medically Necessary services.

G. Contractor may provide voluntary services that are neither State-approved Community Supports nor Covered Services when medically appropriate for the Member, in accordance with 42 CFR section 438.3(e)(1). Such voluntary services are not subject to the terms of this Section 4.5 and are subject to the limitations of 42 CFR section 438.3(e)(1).

4.5.3 Community Supports Providers

A. Community Supports Providers are entities that Contractor has determined can provide Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*).

B. Contractor must enter into Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers for the delivery of Community Supports elected by Contractor.

C. Contractor must ensure all Community Supports Providers for whom a State-level Enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 22-013. If APL 22-013 does not apply to a Community Supports Provider, Contractor must have a process for verifying qualifications and experience of Community Supports Providers, which must extend to individuals employed by or delivering services on behalf of the Community Supports Provider. Contractor must ensure that all Community Supports Providers meet the capabilities and standards required to be a Community Supports Provider.

D. In accordance with Exhibit A, Attachment III, Subsection 4.5.9 (*Data System Requirements and Data Sharing to Support Community Supports*), Contractor must support Community Supports Provider access to systems and processes allowing them to do the following, at a minimum:

1) Obtain and document Member Information including eligibility, Community Supports authorization status, Member authorization for data sharing (to the extent required by law), and other relevant demographic and administrative information; and

2) Support Community Supports Provider notification to Contractor, ECM Providers, and Member's Primary Care Provider (PCP), as applicable, when a referral has been fulfilled, as described in Exhibit A, Attachment III, Subsection 4.5.9 (*Data System Requirements and Data Sharing to Support Community Supports*).

E. To the extent Contractor elects to offer Community Supports, Contractor may coordinate its approach with other Medi-Cal managed care health plans offering Community Supports in the same county.

F. Contractor must prioritize contracting with locally available community-based organizations that have experience working with eligible populations and delivering the outlined Community Supports services (e.g., Supportive housing providers, Skilled Nursing Facilities (SNFs), medically tailored meals providers).

4.5.4 Community Supports Provider Capacity

A. Contractor must develop a robust network of Community Supports Providers to deliver all elected Community Supports.

B. If Contractor is unable to offer its elected Community Supports to all eligible Members for whom it is medically appropriate and cost-effective within a particular county, Contractor must submit ongoing progress reports to DHCS in a format and manner specified by DHCS.

C. Contractor must ensure all of its Community Supports Providers have sufficient capacity to receive referrals for Community Supports and provide the agreed-upon volume of Community Supports to Members who are authorized for such services on an ongoing basis.

4.5.5 Community Supports Model of Care

A. Contractor must develop a Community Supports MOC in accordance with the DHCS-approved Community Supports MOC template. The Community Supports MOC must specify Contractor's framework for providing Community Supports, including a listing of its Community Supports Providers and policies and procedures for partnering with Community Supports Providers for the provision of Community Supports.

B. In developing and executing Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers, Contractor must incorporate all requirements and policies and procedures described in its Community Supports MOC, in addition to APLs.

C. Contractor may collaborate with other Medi-Cal managed care health plans within the same county on the development of its Community Supports MOC.

D. Contractor must submit its Community Supports MOC for DHCS review and approval. Contractor must also submit to DHCS any significant changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any such occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs. Significant changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services; approved policies and procedures; and Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement boilerplates, as appropriate.

4.5.6 Identifying Members for Community Supports

A. Contractor must utilize a variety of methods to identify Members who may benefit from Community Supports, in accordance with all applicable D**H**C~~H~~S APLs.

B. Contractor must develop policies and procedures for Community Supports, and submit its policies and procedures to DHCS for review and approval prior to implementation. Contractor's policies and procedures must address the following, at a minimum:

1) How Contractor will identify Members eligible for Community Supports;

2) How Contractor will notify Members; and

3) How Contractor will receive requests to evaluate Members for Community Supports from Providers; community-based entities; and Member or Member's family, legal guardians, Authorized Representatives (ARs), and caregivers.

Back to Agenda Back to Item

C. Contractor must submit all Member notices to DHCS for review and approval prior to implementation.

D. Contractor must ensure that Member identification methods for Community Supports are equitable and do not exacerbate or contribute to existing racial and ethnic disparities.

4.5.7 Authorizing Members for Community Supports and Communication of Authorization Status

A. Contractor must develop and maintain policies and procedures that explain how Contractor will authorize Community Supports for eligible Members in an equitable and non-discriminatory manner. Contractor must submit its policies and procedures to DHCS for review and approval prior to implementation.

1) Contractor's policies and procedures must include a framework for considering medical appropriateness in relation to Contractor's proposed approach for providing Community Supports.

2) Each Community Support authorization request must be considered separately for a Member. Contractor must evaluate each authorization request for medical appropriateness. Receiving one Community Support does not preclude a Member from being authorized for additional Community Supports unless a conflict is specified by DHCS.

B. Contractor must monitor and evaluate Community Supports authorizations to ensure they are equitable and non-discriminatory. Contractor must have policies and procedures in place for immediate actions that it will undertake if monitoring/evaluation processes reveal that service authorizations have had an inequitable effect.

C. Contractor's policies and procedures must include detailed documentation that a Network Provider, or Contractor's staff Provider using their professional judgement has determined it to be medically appropriate for the Member to receive Community Supports as it is likely to reduce or prevent the need for acute care or other California Medicaid State Plan services in accordance with APLs and to be defined in forthcoming guidance.

D. Contractor must develop and maintain policies and procedures to ensure Members do not experience undue delays pending the authorization process for Community Supports. If Medically Necessary, Contractor must

make available the California Medicaid State Plan services that the Community Supports replace, pending authorization of the requested Community Supports.

E. Contractor must have policies and procedures for expediting the authorization of certain Community Supports for urgent needs, as appropriate, and that identify the circumstances in which any expedited authorization processes apply, in accordance with APLs.

F. When a Member has requested Community Supports, directly or through a Provider, community-based organization, or other entity, Contractor must notify the requestor and the Member of Contractor's decision regarding Community Supports authorization, in accordance with APLs. If the Member is enrolled in ECM, Contractor must ensure the ECM Provider is informed of the Community Supports authorization decision.

G. Members always retain the right to file Appeals and/or Grievances if they request one or more Community Supports offered by Contractor but were not authorized to receive the requested Community Supports.

H. For Members who sought Community Supports offered by Contractor, but were not authorized to receive the Community Supports, Contractor must submit necessary data to monitor Appeals and Grievances as well as follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011.

4.5.8 Referring Members to Community Supports Providers for Community Supports

A. Contractor must develop and maintain policies and procedures to define how Community Supports Provider referrals will occur. Contractor must submit to DHCS policies and procedures for review and approval prior to implementation.

1) For Members enrolled in ECM, Contractor's policies and procedures must address how Contractor will work with the ECM Provider to coordinate the Community Supports referral and communicate the outcome of the referral back to the ECM Provider.

2) Contractor's policies and procedures must include expectations and procedures to ensure referrals occur in a timely manner after service authorization.

B. If the Member prefers a particular Community Supports Provider and Contractor is aware of this preference, Contractor must follow those preferences, to the extent practicable.

C. Contractor must track referrals to Community Supports Providers to verify if the authorized service has been delivered to the Member.

If the Member receiving Community Supports is also receiving ECM, Contractor must monitor to ensure that the ECM Provider tracks whether the Member receives the authorized service from the Community Supports Provider.

D. Contractor must not require Member authorization for Community Supports-related data sharing as a condition of initiating delivery of Community Supports, unless such authorization is required by State or federal law.

E. Contractor must develop and maintain policies and procedures for its network of Community Supports Providers to:

1) Ensure the Member agrees to receive Community Supports;

2) Where required by applicable law, ensure that Members authorize information sharing with Contractor and all others involved in the Member's care as needed to support the Member and maximize the benefits of Community Supports, in accordance with APLs, laws, and regulations;

3) Provide Contractor with Member-level records of any obtained authorization for Community Supports-related data sharing which are required by law, and to facilitate ongoing data sharing with Contractor; and

4) Obtain Member authorization to communicate electronically with the Member, Member's family, legal guardians, ARs, caregivers, and other authorized support persons, if Contractor intends to do so.

4.5.9 Data System Requirements and Data Sharing to Support Community Supports

A. Contractor must use systems and processes capable of tracking Community Supports referrals, access to Community Supports, and Grievances and Appeals.

Contractor must support Community Supports Provider access to systems and processes allowing them to track and manage referrals for Community Supports and Member information.

B. Consistent with federal, State and, if applicable, local privacy and confidentiality laws, Contractor must ensure Community Supports Providers have access to the below as part of the referral process to Community Supports Providers:

1) Demographic and administrative information confirming the referred Member's eligibility and authorization for the requested service;

2) Appropriate administrative, clinical, and social service information that Community Supports Providers might need to effectively provide the requested service; and

3) Billing information necessary to support the Community Supports Providers' ability to submit claims or invoices to Contractor.

C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS in compliance with data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with H&S section 130290, when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.

4.5.10 Contractor's Oversight of Community Supports Providers

A. Contractor must comply with all State and federal reporting requirements.

B. Contractor must perform oversight of Community Supports Providers, holding them accountable for all Community Supports requirements contained in this Contract and all applicable APLs.

C. Contractor must use all applicable APLs to develop its Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers and must incorporate all of its Community Supports Provider requirements. Contractor must submit its Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, as appropriate,

with Community Supports Providers to DHCS for review and approval in a form and manner specified by DHCS.

D. To streamline Community Supports implementation:

1) Contractor must hold Community Supports Providers responsible for the same reporting requirements as are required of Contractor by DHCS;

2) Contractor must not impose mandatory reporting requirements that are alternative or additional to those required for Encounter Data and supplemental reporting as described in Subsection 4.5.13 (*Community Supports Reporting Requirements*); and

3) Contractor may collaborate with other Medi-Cal managed care health plans within the same county on reporting requirements and oversight.

E. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of Community Supports Providers, unless by mutual consent with the Community Supports Provider.

F. Contractor must provide Community Supports training and technical assistance to Community Supports Providers, including in-person sessions, webinars, and calls, as necessary, in addition to Network Provider training requirements, as applicable, as described in Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training*).

G. Contractor must not require Community Supports Providers to use a contractor-specific portal for day-to-day documentation of services. However, this prohibition does not preclude providers and Contractor from mutually agreeing to use of portals to facilitate reporting and other administrative transactions.

4.5.11 Delegation of Community Supports Administration to Network Providers, Subcontractors, or Downstream Subcontractors

A. Contractor may enter into Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate, with other entities to administer Community Supports in accordance with the following:

1) Contractor must maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, as

described in Exhibit A, Attachment III, Section 3.1 (*Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties*);

2) Contractor must develop and maintain DHCS-approved policies and procedures to ensure Network Providers, Subcontractors, and Downstream Subcontractors meet required responsibilities and functions as described in Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*);

3) Contractor must evaluate the prospective Network Provider's, Subcontractor's, or Downstream Subcontractor's ability to perform services as described in Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*);

4) Contractor must ensure the Network Provider's, Subcontractor's, or Downstream Subcontractor's Community Supports Provider capacity is sufficient to serve all Populations of Focus;

5) Contractor must, as applicable, report to DHCS the names of all Subcontractors and Downstream Subcontractors by Subcontractor and Downstream Subcontractor type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan*); and

6) Contractor must make all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment III, Subsection 3.1.5. (*Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*).

B. Contractor must ensure all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements mirror the requirements set forth in this Contract and APLs, as applicable to the Network Provider, Subcontractor, or Downstream Subcontractor.

Back to Agenda Back to Item

C. Contractor may collaborate with its Network Providers, Subcontractors, and Downstream Subcontractors on its approach to Community Supports to minimize divergence in how the Community Supports will be implemented between Contractor and its Network Providers, Subcontractors and Downstream Subcontractors, and to ensure a streamlined, seamless experience for Community Supports Providers and Members.

4.5.12 Payment of Community Supports Providers

A. Contractor must pay contracted Community Supports Providers for the provision of authorized Community Supports to Members in accordance with established Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements between Contractor and each Community Supports Provider.

B. Contractor must utilize the claims timeline and process as described in Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*) to ensure timely payment of claims, bills, or invoices.

C. Contractor must identify any circumstances under which payment for Community Supports must be expedited to facilitate timely delivery of the Community Supports to the Member, such as recuperative care for a Member who is homeless and being discharged from the hospital.

For such circumstances, Contractor must develop and maintain policies and procedures to ensure payment to the Community Supports Provider is expedited. Contractor must submit these policies and procedures to DHCS for review and approval prior to implementation.

D. Contractor must ensure Community Supports Providers submit a claim for rendered Community Supports, to the greatest extent possible.

1) If a Community Supports Provider is unable to submit a claim for Community Supports rendered, Contractor must ensure the Community Supports Provider apply the DHCS approved billing and guidance to submit invoices, located at https://www.dhcs.ca.gov/Documents/MCQMD/ECM-and-Community-Supports-Billing-and-Invoicing-Guidance.pdf.

2) Upon receipt of such an invoice, Contractor must document the Encounter for the Community Supports rendered using the standard HCPCS code(s) and associated modifier(s) set by the State, located at

https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf.

4.5.13 Community Supports Reporting Requirements

A. In the Community Supports MOC, Contractor must include details on the Community Supports Contractor plans to offer, including which counties Community Supports will be offered and its network of Community Supports Providers.

B. After implementation of Community Supports, Contractor must submit the following data and reports to DHCS to support DHCS oversight of Community Supports:

1) Encounter Data

a) Contractor must submit all Community Supports Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS. Contractor must comply with DHCS guidance on billing and invoicing standards for Contractor to use with Community Supports Providers.

b) Contractor must submit to DHCS all Community Supports Encounter Data, including Encounter Data for Community Supports generated under Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements.

c) In the event the Community Supports Provider is unable to submit Community Supports Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor must convert Community Supports Providers' invoicing and billing data into the national standard specifications and code sets, for submission to DHCS.

d) Encounter Data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform Health Equity initiatives and efforts to mitigate Health Disparities undertaken by DHCS.

2) Supplemental reporting on a schedule and in a form to be defined by DHCS.

Back to Agenda Back to Item

C. Contractor must timely submit any related data requested by DHCS, Centers for Medicare & Medicaid Services (CMS), or an independent entity conducting an evaluation of Community Supports including, but not limited to:

1) Data to evaluate the utilization and effectiveness of Community Supports.

2) Data necessary to monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken.

3) Data necessary to monitor Member Appeals and Grievances associated with Community Supports.

D. In the event of underperformance by Contractor in relation to its administration of Community Supports, DHCS may impose sanctions in accordance with Exhibit E, Section 1.19 (*Sanctions*).

4.5.14 Community Supports Quality and Performance Incentive Program

A. Contractor must meet all quality management and Quality Improvement requirements described in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program (QIHETP)*), and any additional quality requirements for Community Supports set forth in associated guidance from DHCS.

B. Contractor may participate in a performance incentive program related to adoption of Community Supports, building infrastructure and Provider capacity for Community Supports, related health care quality and outcomes, and other performance milestones and measures, in accordance with APL 23-003 or other technical guidance.

Exhibit A, ATTACHMENT III

4.6 Member Grievance and Appeal System

4.6.1 Grievance and Appeal Program Requirements
4.6.2 Grievance Process
4.6.3 Discrimination Grievances
4.6.4 Notice of Action
4.6.5 Appeal Process
4.6.6 Responsibilities in Expedited Appeals
4.6.7 State Hearings and Independent Medical Reviews
4.6.8 Continuation of Services Until Appeal and State Hearing Rights Are Exhausted
4.6.9 Grievance and Appeal Reporting and Data

4.6 Member Grievance and Appeal System

4.6.1 Grievance and Appeal Program Requirements

Contractor must have in place a Member Grievance and Appeal system that complies with 42 Code of Federal Regulations (CFR) sections 438.228 and 438.400 - 424, 28 California Code of Regulations (CCR) sections 1300.68 and 1300.68.01, and 22 CCR section 53858 for Covered Services including Contractor's selected Community Supports under 42 CFR section 438.3(e)(2). Contractor must follow Grievance and Appeal requirements set forth in, and use all notice templates included in, All Plan Letter (APL) 21-011. Contractor must ensure that its Grievance and Appeal system meets the following requirements:

A. Allows the Member, or a Provider or Authorized Representative (AR) with the Member's written consent, to file a Grievance, or request an Appeal with Contractor either orally or in writing.

B. Ensures timely written acknowledgement of each Grievance or Appeal, and provides a notice of resolution to the Member as quickly as the Member's health condition requires, not to exceed 30 calendar days from the date the Member makes an oral or written request to Contractor for a standard Grievance or Appeal or 72 hours for an expedited Grievance or Appeal. Contractor must notify the Member, Provider, or AR with a written resolution of the Grievance or Appeal in the Member's preferred language as required by 42 CFR sections 438.10 and 438.404, W&I section 14029.91, and 22 CCR section 53876.

C. Ensures that Members are given assistance when completing Grievance and Appeal forms and all other procedural steps. Required assistance includes, but is not limited to, providing Members with all documents Contractor relied on for its decision, and providing Auxiliary Aid and services upon request, such as translation and interpreter services, use of alternative formats for all documents Contractor relied upon for its decision, and a toll-free number with TTY/TDD and interpreter capability.

D. Ensures that the person making the final decision for the proposed resolution of a Grievance or Appeal has neither participated in any prior decisions related to the Grievance or Appeal, nor is a subordinate of someone who has participated in the prior decision. Contractor must ensure that all Grievance or Appeals related to medical Quality of Care issues be immediately submitted to Contractor's medical director for action. Contractor must ensure that the person making the decision on the Grievance or Appeal has clinical expertise in treating a Member's condition or disease when deciding:

1) An Appeal of a denial based on lack of Medical Necessity or that the service is experimental or investigational;

2) A Grievance regarding denial of a request for expedited resolution of an Appeal; and

3) Any Grievance or Appeal involving clinical issues.

E. Considers all comments, documents, records, and other information submitted by the Member, Provider, or AR, regardless of whether Contractor had the Member's additional information during the initial review.

F. Ensures that Members are given a reasonable opportunity to present evidence and testimony, and make legal or factual arguments, in person, by telephone, or in writing, in support of their Grievance or Appeal. Contactor must inform Members that they must submit additional evidence for Contractor to consider within the 30-calendar-day review timeframe for an Appeal and within the 72-hour timeframe for resolving an expedited Appeal.

G. Ensures that Notices of Appeal Resolution (NAR) be in a format and a language that, at a minimum, meets the standards set forth in 42 CFR section 438.10, W&I section 14029.91, 22 CCR section 53876, and Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*). Contractor must ensure that language assistance taglines and a nondiscrimination notice meeting the minimum requirements in APL 21-004 accompanies each Member notification, and that the nondiscrimination notice is made available, upon request or as otherwise required by law, in all of the Threshold Languages/Threshold or Concentration Standard Languages and Americans with Disabilities Act of 1990 (ADA)-compliant, accessible formats as needed by Members to effectively understand Contractor's notices.

H. Provides oral notice of the resolution of an expedited Appeal to the Member, Provider, or AR within 72 hours.

I. Provides Contractor's Grievance and Appeal policies and procedures to Network Providers, Subcontractors, and Downstream Subcontractors at the time that they enter into a Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement. Contractor must ensure that Network Providers, Subcontractors, and Downstream

Back to Agenda Back to Item

Subcontractors are trained on and immediately notified of any changes to Contractor's Grievance and Appeal policies and procedures.

J. Maintains policies and procedures for compiling, aggregating, and reviewing Grievance and Appeal data for use in Contractor's Quality Improvement Strategy (QIS). Contractor must regularly analyze Grievance and Appeal data to identify, investigate, report, and act upon systemic patterns of improper service denials and other trends impacting health care access and delivery to Members. Contractor must impose necessary Corrective Action to remedy all identified deficiencies.

K. Maintains records of Grievances and Appeals in a manner accessible to DHCS and to the Centers for Medicare & Medicaid Services (CMS), upon request. Contractor must review Grievance and Appeal data and information as part of its ongoing monitoring procedures as well as for updates and revisions to its QIS. The record of each Grievance or Appeal must contain, at a minimum, all information set forth in 42 CFR section 438.416(b). Contractor must ensure that all documents and records, whether in written or electronic format, generated or obtained by Contractor in the course of responding to Adverse Benefit Determinations (ABD), Grievances, Appeals, and Independent Medical Reviews (IMRs) are retained for at least 10 years pursuant to 42 CFR section 438.3(u).

4.6.2 Grievance Process

Contractor's policies and procedures must include all required information set forth below for Grievances and the expedited review of Grievances as required under 42 CFR sections 438.402, 438.406, and 438.408; 28 CCR sections 1300.68 and 1300.68.01; and 22 CCR section 53858:

A. A policy and procedure for Members to file a Grievance with Contractor at any time to express dissatisfaction about any matter other than a notice of ABD.

B. A policy and procedure to allow Members to file a Grievance to contest Contractor's unilateral decision to extend the timeframe for resolution of an Appeal or expedited Appeal.

C. A policy and procedure to ensure that every Grievance involving clinical issues that is submitted is reported to qualified medical professionals with appropriate clinical expertise and is escalated to Contractor's medical director as needed, to ensure the Grievance is properly handled.

D. A policy and procedure to ensure that Contractor's staff monitor Grievances to identify issues that require Corrective Action. Grievances related to medical Quality of Care issues must be referred to qualified medical professionals with appropriate clinical expertise and be escalated to Contractor's medical director as needed.

E. A policy and procedure for Contractor to provide written acknowledgement to the Member within five calendar days of receipt of the Grievance. The acknowledgement letter must advise the Member that the Grievance has been received; provide the date of receipt; and provide the name, telephone number, and address of the representative who the Member, their Provider, or their AR may contact about the Grievance.

4.6.3 Discrimination Grievances

Contractor must process Discrimination Grievances as required by federal and State nondiscrimination law and DHCS policy, as stated in 45 CFR section 84.7, 34 CFR section 106.8, 28 CFR section 35.107, W&I section 14029.91(e)(4), and APL 21-004.

A. Contractor must designate a Discrimination Grievance coordinator responsible for ensuring compliance with federal and State nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or State nondiscrimination law.

B. Contractor must adopt and implement written policies and procedures to ensure the prompt and equitable resolution of Discrimination Grievances. Contractor must not require a Member or Potential Member to file a Discrimination Grievance with Contractor before filing with the DHCS Office of Civil Rights or the U.S. Department of Health and Human Services Office for Civil Rights.

C. Within ten calendar days of mailing a Discrimination Grievance resolution letter, Contractor must submit information regarding the Discrimination Grievance to the DHCS Office of Civil Rights, as specified in APL 21-004 **to DHCS.DiscriminationGrievances@dhcs.ca.gov.**

D. Contractor must inform Members on its website that Discrimination Grievances may be filed directly with the DHCS Office of Civil Rights and must include contact information for the DHCS Office of Civil Rights, as required by Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*).

4.6.4 Notice of Action

When Contractor makes an authorization decision, it must send a Notice of Action (NOA). A NOA is a notice of any action that impacts a Member's ability to obtain Covered Services or other benefits Contractor is required to provide under this Contract. A NOA includes, but is not limited to, a notice of ABD for a requested health care service under 42 CFR sections 438.210(d) and 438.404, including requested Community Supports that Contractor has elected to cover under 42 CFR section 438.3(e)(2).

Contractor's failure to render a decision and send a written NOA to the Member within the required timeframes below is considered a denial of the requested service and therefore constitutes an ABD on the date that Contractor's timeframe for approval expires, in accordance with 42 CFR section 438.404(c)(5). In cases where Contractor fails to meet the required notice timeframes, the Member may immediately request an Appeal with Contractor and Contractor must send the Member written notice of all Appeal rights.

A. Standard Authorization Requests

1) Contractor must ensure a NOA is sent when approving, denying or modifying a Provider's Prior Authorization or concurrent request for health care services (excluding pharmacy services, but including Community Supports) for a Member within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than five Working Days from Contractor's receipt of information reasonably necessary and requested by Contractor to make a determination, not to exceed 14 calendar days following Contractor's receipt of the request for service, in accordance with 42 CFR sections 438.210(d)(1) and 438.404(c)(3); and

2) Contractor must notify the requesting Provider of its authorization decision within 24 hours of the decision and send the written NOA to the Member within two Working Days in accordance with H&S section 1367.01(h)(1) and (3).

3) Contractor must send the written NOA approving, denying, or modifying the authorization request. Contractor must approve, deny, or modify the request and send the written NOA within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than five Working Days from Contractor's receipt of information reasonably necessary and requested by Contractor to make a determination, not to exceed 14

calendar days in accordance with 42 CFR sections 438.210(d)(1) and 438.404(c)(3); and

4) Contractor must send the written NOA to the Member with sufficient time to allow for continuation of benefits pursuant to 42 CFR section 438.420.

B. Expedited Authorization Requests

1) In instances where a Provider indicates, or Contractor determines, that the standard request timeframe may seriously jeopardize the Member's life; health; or ability to attain, maintain, or regain maximum function, Contractor must approve, modify, or deny a Prior Authorization or concurrent request for health care services, and send the written NOA, in a timeframe which is appropriate for the nature of the Member's condition, but no longer than 72 hours from receipt of the authorization request in accordance with 42 CFR section 438.210(d)(2) and (d)(2)(i).

2) Contractor must send the written NOA approving, denying, or modifying the authorization request. Contractor must send the written NOA to the Member with sufficient time to allow for continuation of benefits pursuant to 42 CFR section 438.420.

3) Contractor must approve, modify, or deny the request within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than 72 hours from Contractor's receipt of additional information requested by Contractor to make a determination. Contractor's written notice to the Member must be sent with sufficient time to allow the Member to request Aid Paid Pending if applicable.

C. Retrospective Review

Contractor must approve, modify, or deny a Provider's request for Retrospective Review authorization for health care services provided to a Member, and send the written NOA to the Member, within 30 calendar days from receipt of information that is reasonably necessary to make a determination.

D. Terminations, Suspensions, or Reductions

1) For terminations, suspensions, or reductions of previously authorized services, Contractor must notify Members at least ten

calendar days before the date of the action pursuant to 42 CFR section 431.211, with the exception of circumstances permitted under 42 CFR sections 431.213 and 431.214.

2) For purposes of auditing, the postmark on Contractor's notice to the Member will be used to confirm compliance with all authorization request timeframes and notice requirements set forth in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*).

E. Required Information in Contractor's NOA Informing Member of Notice of ABDs.

Contractor must ensure all NOAs informing a Member of an ABD are in writing in a format and language that, at a minimum, meets the standards set forth 42 CFR sections 438.10, 438.404, and 438.408; W&I section 14029.91; 22 CCR section 53876; and Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*), and APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services. Contractor's NOA informing of an ABD must include all of the following:

1) A clear and concise explanation of the action that Contractor or its Network Provider has taken or intends to take, including a fully translated written notice with a fully translated clinical rationale for Contractor's decision at the point of each determination;

2) The reason for the action, including notification to the Member of the right to be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and any other information Contractor relied on for the decision, including clinical criteria; Medical Necessity criteria; and any processes, strategies, or evidentiary standards relied on for the decision;

3) The Member's right to request an Appeal with Contractor no later than 60 calendar days from the date on the NOA, and information on exhausting Contractor's one-level Appeal system;

4) The Member's right to an expedited Appeal if the Member's health condition requires resolution in less than 72 hours and information on how to request an expedited Appeal;

Back to Agenda Back to Item

5) The Member's rights and information on the process to request a State Hearing after having exhausted Contractor's internal Appeal process and having received notice that Contractor is upholding its action. The NOA must also advise that the Member may request a State Hearing in cases where Contractor fails to send a NAR or notice of extension in response to the Appeal within 30 calendar days of the Member's request for an Appeal. This is known as Deemed Exhaustion pursuant to 42 CFR section 438.402(c)(1)(i)(A);

6) The Member's right to continue receiving Covered Services pending the resolution of the Appeal, and Contractor's obligation to continue benefits as required by 42 CFR section 438.420 and Exhibit A, Attachment III, Subsection 4.6.8 (*Continuation of Services Until Appeal and State Hearing Rights Are Exhausted*) below; and

7) If applicable, the Member's right to request a clinical review of Contractor's action, called an IMR, from DMHC and that the Member must request an IMR before there is a final decision on their State Hearing.

F. For visually impaired Members, Contractor must provide the NOA in the Member's selected alternative format in order to be considered adequate notice. Contractor must not deny, delay, modify, limit, or terminate services or treatments without providing adequate notice within the timeframes stated in this Exhibit A, Attachment III, Subsection 4.6.4 (*Notice of Action*). In accordance with APL 22-002, Contractor must calculate the appropriate timeframe(s) for a visually impaired Member to take action from the date of receiving adequate notice in their selected alternative format, including all deadlines for Appeals.

G. Contractors are not permitted to make any changes to DHCS' NOA templates or the NOA "Your Rights" Attachment without prior review and approval from DHCS, except to insert the specific reasons for Contractor's action to the Member, as required.

4.6.5 Appeal Process

Pursuant to 42 CFR sections 438.228 and 438.400 - 424, Contractor must have an Appeal process as required below to attempt to resolve Member Appeals before the Member requests a State Hearing or an IMR. Contractor must have only one level of Appeal for Members. Upon a Member's request, Contractor must assist any Member in preparing their Appeal, which includes assisting the

Member with navigating Contractor's website, providing all documents that Contractor relied on for its decision, and providing the Appeal form to the Member.

A. Following the receipt of a NOA, a Member has 60 calendar days from the date on the NOA to file a request for an Appeal either orally or in writing. The Member, or a Provider or AR acting on behalf of the Member and with the Member's written consent, may request an Appeal. Unless the Member is requesting an expedited Appeal, the date of the Member's oral or written request for an Appeal establishes the filing date for the Appeal. Contractor must resolve the Appeal within 30 calendar days of the Member's oral or written request for an Appeal.

B. If Contractor fails to send a written NOA within 30 calendar days or fails to comply with notice and language translation requirements in 42 CFR sections 438.10, 438.404, and 438.408; W&I section 14029.91; 22 CCR section 53876; and Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*), the Member is deemed to have exhausted Contractor's internal Appeal process and may request a State Hearing pursuant to 42 CFR section 438.402(c)(1)(i)(A).

C. Contractor's NOA informing the Member of its NAR must, at a minimum, indicate whether Contractor upheld its decision on the Appeal and the date of Contractor's decision on the Appeal. For decisions not wholly in the Member's favor, Contractor's NAR must, at a minimum, include:

   1) Member's right to request a State Hearing;

   2) How to request a State Hearing;

   3) That the Member has a right to continuation of benefits during the State Hearing, and that Contractor is obligated to continue benefits as long as the requirements of 42 CFR section 438.420 are met;

   4) If applicable, the right to request an IMR or a review of Contractor's decision by DMHC, and that the IMR must be requested before there is a final State Hearing decision; and

   5) The DHCS-approved "Your Rights" Attachment.

D. If Contractor reverses its decision during the Appeal, it must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the

Back to Agenda Back to Item

date it reverses the action if the disputed services were not provided during the Appeal.

E. Contractor must pay for disputed services if the Member received the disputed services while the Appeal was pending.

F. Contractor must provide the Member or AR the opportunity before and during their Appeal process to examine their case file. Contractor must provide, sufficiently in advance of the resolution timeframe and free of charge, the Member's case file, including Medical Records, clinical criteria, guidelines, and all documents and records Contractor relied on during the Appeal process for its decision. Contractor must assist any Member who requires assistance preparing their Appeal.

G. Contractor may withdraw a Grievance or Appeal upon Member request if performed in compliance with the established Grievance and Appeals processes required in this Contract and federal and State laws and regulations. Where a Grievance or Appeal was filed by a Provider or AR of a Member, written Member consent is required for a Provider or AR to withdraw the Grievance or Appeal.

4.6.6 Responsibilities in Expedited Appeals

Contractor must implement and maintain policies and procedures as described below to resolve expedited Appeals. Contractor must follow the expedited Appeal process when it determines or the requesting Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life; physical or mental health; or ability to attain, maintain, or regain maximum function.

A. A Member, or a Provider or an AR with the Member's written consent, may file an expedited Appeal either orally or in writing. No additional follow-up from the Member is required. Contractor must ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's Appeal.

B. Contractor must inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person, by phone, or in writing, sufficiently in advance of the resolution timeframe.

C. Contractor must resolve an expedited Appeal as quickly as the Member's health condition requires, but no later than 72 hours from the day Contractor receives the request for an expedited Appeal.

D. Contractor must make a reasonable effort to provide oral notice of an expedited Appeal decision.

E. If Contractor denies a request for an expedited resolution of an Appeal, it must process the request for an Appeal in accordance with the standard Appeal process timeframes for resolutions and extensions as required in Exhibit A, Attachment III, Subsection 4.6.5 (*Appeal Process*).

4.6.7 State Hearings and Independent Medical Reviews

A. State Hearings

1) The Member, or a Provider or AR with the Member's written consent, may request a State Hearing:

a) After receiving a NAR confirming that Contractor has upheld its ABD, and the request is made within 120 calendar days from the date on the NAR;

b) In cases of Deemed Exhaustion, due to Contractor's failure to comply with Appeal notice and timing requirements as required by 42 CFR sections 438.10, 438.402, 438.404, 438.406, 438.408, and 438.410; W&I sections 10951 and 10951.5; and as stated in this Contract, the Member may immediately request a State Hearing. In cases of Deemed Exhaustion, Contractor must not request a dismissal of the State Hearing based on a failure to exhaust Contractor's internal Appeal process; or

c) If Contractor fails to provide Appeal notices required in 42 CFR section 438.408 to a Member with a visual impairment, in the Member's selected alternative format and within the applicable federal or State timeframes, the Member is deemed to have exhausted Contractor's internal Appeal process and may immediately request a State Hearing. In such cases, Contractor is prohibited from requesting dismissal of a State Hearing on the basis of failure to exhaust Contractor's internal Appeal process.

2) Upon request from the Member, Contractor must assist the Member with preparing for the State Hearing by providing the Member or their AR with the Member's case file, including Medical Records, other documents and records, guidelines, clinical criteria, and any new or additional evidence that Contractor relied on for its

Back to Agenda Back to Item

initial denial and anything Contractor considered during its internal Appeal process. This information must be provided free of charge and sufficiently in advance of the resolution timeframe.

3) Contractor must provide its statement of position for the State Hearing to the Member and to the California Department of Social Services at least two Working Days before the State Hearing.

4) Contractor must ensure that an employee familiar with the facts of the case and Contractor's basis for upholding its ABD is available to actively participate in the State Hearing by ensuring that the employee is available and prepared to present Contractor's position and be subject to cross examination at the State Hearing as required by 42 CFR sections 431.205 and 431.242 and *Goldberg v. Kelly* (1970) 397 US 254. Contractor must ensure that it provides accurate contact information for its State Hearing representative to ensure an appearance at the State Hearing via telephone or in person. Additionally, to ensure Member's right to due process during the State Hearing process, Contractor must ensure that a statement of position is timely filed with the California Department of Social Services and provided to the Member not less than two Working Days before the hearing as required by W&I section 10952.5.

5) In cases where the State Hearing decision overturns Contractor's decision, Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date Contractor receives notice that the State Hearing decision reversed Contractor's decision.

6) Contractor must pay for disputed services if the Member received the disputed services while the State Hearing was pending.

7) The parties to a State Hearing must include Contractor as well as the Member, their AR, or the representative of a deceased Member's estate.

8) Contractor must notify Members that the State must make a decision for a State Hearing within 90 calendar days of the date of the State Hearing request. For an expedited State Hearing, DHCS will take final administrative action as expeditiously as the individual's health condition requires, but no later than three Working Days after Contractor provides DHCS with the case file

and information supporting its Appeal of an ABD pursuant to W&I section 10951.5. Contractor must also comply with all other requirements as required by 42 CFR sections 438.410 and 438.404(a), W&I section 14029.91(e), 22 CCR sections 53876 and 53895, and APL 21-011.

B. Contractor's Obligations for Expedited State Hearings

1) Within two Working Days of being notified by DHCS or the California Department of Social Services that a Member has filed a request for State Hearing which meets the criteria for expedited resolution, Contractor must deliver directly to the designated/appropriate California Department of Social Services administrative law judge all information and documents which either support, or which Contractor considered in connection with, the action which is the subject of the expedited State Hearing. This includes, but is not limited to, copies of the relevant Treatment Authorization Request and NOA, plus any pertinent NAR and all documents Contractor relied on for its denial, including clinical criteria and guidelines. If the NOA or NARs are not in English, Contractor must transmit fully translated copies to the California Department of Social Services along with copies of the original NOA and NARs.

2) Contractor must ensure that an employee familiar with the facts of the case and Contractor's basis for upholding its ABD is available to actively participate in the expedited State Hearing by ensuring that the employee is available and prepared to present Contractor's position during cross examination at the State Hearing as required by 42 CFR sections 431.205 and 431.242 and *Goldberg v. Kelly* (1970) 397 US 254. Contractor must ensure that it provides accurate contact information for its State Hearing representative to ensure an appearance at the Hearing via telephone or in person. Additionally, to ensure Member's right to due process during the State Hearing process, Contractor must ensure that its completed case file, including the statement of position, is timely filed with the California Department of Social Services as required by W&I section 10951.5(b)(1).

C. Independent Medical Review

1) If applicable to Contractor's plan model, Contractor must inform Members of the right to request an IMR of an action resulting in a Member request for an Appeal, or the outcome of an Appeal.

2) An IMR must be requested by the Member, or a Provider or AR with written authorization from the Member to act on the Member's behalf. Contractor must not require a Member to request an IMR before, or use one as a deterrent to, requesting a State Hearing.

3) IMRs must be conducted by the California Department of Managed Healthcare (DMHC) independently from either the Member or Contractor, and at no cost to the Member.

4) IMRs do not extend any of the time frames stated in this Contract for Appeals, and do not disrupt the continuation of Covered Services per 42 CFR section 438.420.

4.6.8 Continuation of Services Until Appeal and State Hearing Rights Are Exhausted

A. Contractor must automatically continue providing the disputed services to the Member while the Appeal and State Hearing are pending if all of the following conditions are met:

1) The Member filed their Appeal within the required timeframes set forth in 42 CFR section 438.420;

2) The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

3) The disputed services were ordered by the Member's Provider; and

4) The period covered by the original authorization has not expired.

B. If Contractor, at the Member's request, continues or reinstates the provision of disputed services while an Appeal or State Hearing is pending, those services must continue until:

1) The Member withdraws their request for an Appeal or a State Hearing;

2) The Member fails to request a State Hearing and continuation of disputed services within ten calendar days of when the NOA was sent; or

3) The final State Hearing decision is adverse to the Member.

C. Contractor must pay for disputed services if the Member received the disputed services while the Appeal or State Hearing was pending. Contractor must ensure the Member is not billed for the continued services even if the State Hearing or IMR finds the disputed services were not Medically Necessary.

4.6.9 Grievance and Appeal Reporting and Data

A. Contractor must submit a Grievance and Appeal log to DHCS upon request for Medi-Cal Members only in the form that is required by and submitted to Department of Managed Health Care (DMHC), as set forth in 28 CCR section 1300.68(f), with additional information required by DHCS per 42 CFR section 438.416 and 22 CCR section 53858(e).

B. Contractor must submit Grievance and Appeal data to DHCS monthly as specified in Exhibit A, Attachment III, Section 2.1.5 (*Program Data Reporting*) and APL 20-017.

C. Contractor must comply with the requirements set forth in Exhibit A, Attachment III, Section 2.1 (*Management Information System*) of this Contract for the reporting of Grievance and Appeal data.

D. Contractor must maintain records of Grievances and Appeals and must have policies and procedures in place governing the review of the information as part of its ongoing QIS. Contractor must identify systemic patterns of wrongful denials and impose Corrective Action as necessary. The records must be accurately maintained in a manner accessible to the State and available to CMS upon request. Records must include all required information set forth in 42 CFR section 438.416(b). Contractor must ensure that all documents and records, whether in a written or electronic format, generated or obtained by Contractor in the course of responding to ABDs, Grievances, Appeals, and IMRs are retained for at least 10 years pursuant to 42 CFR section 438.3(u).

Exhibit A, ATTACHMENT III

5.0 Services – Scope and Delivery

DHCS has a longstanding commitment to ensure Members have access to high-quality services. The provisions in this Article lay out DHCS expectations of Contractor for promoting access to medical, behavioral, and social services; increasing integration and collaboration across delivery systems and with local partners; and ultimately improving health outcomes.

Through the provisions in this Article, several key goals of California Advancing and Innovating Medi-Cal (CalAIM) are addressed. For example, Contractor must manage the health care needs of the Member over time through a comprehensive array of person-centered health and social services spanning all levels of intensity of care, from birth to dignified end of life. This Article also includes provisions related to Advance Directives and ensuring that Contractor informs Members of what an Advance Directive is and how to put a valid one in place. This Article contains key provisions related to information Members must receive to help them navigate the health care system including information that must be included in the Member Handbook and Provider Directory.

This Article also address access to evidence-based Behavioral Health care, with a focus on integration with physician health and earlier identification and engagement in treatment for Children, youth, and adults. Provisions included here also implement No Wrong Door policies and outline expectations that Contractor ensure Members receive timely mental health services without delay regardless of the delivery system where they seek care. Contractors are expected to ensure Members maintain treatment relationships with trusted Providers without interruption, to the extent feasible.

This Article lays out expectations for services and access to community-based Providers that provide social support including Dyadic Care Services, Doula services, and Community Health Workers (CHW). The intent for enabling access to these provider types is to improve health outcomes by meeting the Behavioral Health (including emotional health and wellbeing), and physical health needs of culturally diverse populations.

DHCS recognizes the importance of coordination and collaboration with other local partners in order to meet the needs of the whole person. Accordingly, DHCS sets forth requirements for Contractor to engage with local entities to promote Member needs for not only Medically Necessary health care services but also any supportive services as needed to treat the whole person and prevent avoidable negative health and social outcomes for individual Members to treat the whole person. This entails partnerships with Local Health Departments,

Local Educational and Government Agencies, and other local programs and services including county social services departments, Child welfare departments, and justice departments. This Article also establishes oversight of Memorandum of Understanding (MOU) requirements and requires referrals to ensure Member care is coordinated and community-based resources, including Community Supports, are availed. Beyond the MOU requirements, DHCS seeks to embed the whole person care and community-informed care approach within its Population Health Management (PHM) strategy and requires the same of Contractor. As such, this Article includes provisions requiring Contractor engagement with community representatives of diverse cultural and ethnic backgrounds to develop its PHM strategies.

To empower Members to become active participants in their care, DHCS has enhanced existing processes and created new channels for engagement for Members, families, and the community. Historically, Medi-Cal managed care plans are required to maintain a Community Advisory Committee (CAC), which serves to inform Contractor's cultural and linguistic services program. DHCS seeks to elevate the CAC by clarifying its role and member composition and prescribing Contractor's role in providing support for CAC members in order to maximize participation and involvement.

Exhibit A, ATTACHMENT III

5.1 Member Services

5.1.1 Member Rights and Responsibilities
5.1.2 Member Services Staff
5.1.3 Member Information
5.1.4 Primary Care Provider Selection
5.1.5 Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests

5.1 Member Services

5.1.1 Member Rights and Responsibilities

A. Member Rights and Responsibilities

Contractor must develop, implement, and maintain written policies and procedures that set forth the Member's rights and responsibilities and must communicate its policies to its Members, Providers, and, upon request, Potential Members.

1) Contractor's written policies and procedures must include the following Member rights:

a) To be treated with respect, giving due consideration to the Member’s right to privacy and the need to maintain confidentiality of the Member’s Protected Health Information (PHI) and private information.

b) To be provided with information about Contractor’s organization and all services available to Members.

c) To be able to choose their Primary Care Provider (PCP) within Contractor's Network unless the PCP is unavailable or is not accepting new patients.

d) To participate in decision-making regarding their health care, including the right to refuse treatment.

e) To submit Grievances, either verbally or in writing, about Contractor, Providers, care received, and any other expression of dissatisfaction not related to an Adverse Benefit Determination (ABD).

f) To request an Appeal of an ABD within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD) and request how to continue benefits during the in-plan Appeal process through the State Hearing, when applicable.

g) To request a State Hearing, including information on the circumstances under which an expedited State Hearing is available.

h) To receive interpretation services and written translation of critical informing materials in their preferred Threshold Language, including oral interpretation and American Sign Language.

i) To have a valid Advance Directive in place, and an explanation to Members of what an Advance Directive is.

j) To have access to family planning services and sexually transmitted disease services, from a Provider of their choice, without referral or Prior Authorization, either in or outside of Contractor's Network. To have Emergency Services provided in or outside of Contractor's Network, as required pursuant to federal law.

k) To have access to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Indian Health Care Providers (IHCP) outside of Contractor's Network, pursuant to federal law.

l) To have access to, and receive a copy of, their Medical Records, and request that they be amended or corrected, as specified in 45 Code of Regulations (CFR) sections 164.524 and 164.526.

m) To change Medi-Cal managed care plans upon request, if applicable.

n) To access Minor Consent Services.

o) To receive written Member informing materials in alternative formats, including Braille, large size print no smaller than 20 point font, accessible electronic format, and audio format, upon request and in accordance with 42 CFR section 438.10 and 45 CFR sections 84.52(d) and 92.102.

p) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

q) To receive information on available treatment options and alternatives, presented in a manner appropriate for the Member's condition and ability to understand available treatment options and alternatives.

r) To freely exercise these Member rights without retaliation or any adverse conduct by Contractor, Subcontractors, Downstream Subcontractors, Network Providers, or the State.

2) Contractor must provide its written policies and procedures regarding Member rights and responsibilities to its staff and all Network Providers, Subcontractors, and Downstream Subcontractors. Contractor must ensure that its staff, Network Providers, Subcontractors, and Downstream Subcontractors are trained and knowledgeable on Members' rights as required under Exhibit A, Attachment III, Section 3.2 (*Provider Relations*).

B. Member's Right to Confidentiality

Contractor must have policies and procedures in place to ensure Members' rights to confidentiality of PHI and Personal Information (PI) in accordance with 45 CFR parts 160 and 164, and in accordance with Civil Code section 1798 *et seq*.

1) Contractor must ensure that all Subcontractors, Downstream Subcontractors, and Network Providers have policies and procedures in place to guard against unlawful disclosure of PHI, PI, and any other Confidential Information to any unauthorized persons or entities.

2) Contractor must inform and advise Members on the right to confidentiality of their PHI and PI. Contractor must obtain the Member's prior written authorization to release Confidential Information, unless such prior written authorization is not required by State and federal law.

C. Member's Right to Advance Directives

Contractor must have written policies and procedures to ensure Members are informed of what an Advance Directive is and how to put a valid Advance Directive in place. Contractor must have policies and procedures in place to ensure all involved in the Member's care comply with the terms of a Member's valid Advance Directive in accordance with the requirements of 42 CFR sections 422.128 and 438.3(j).

1) Contractor must ensure that its process for a Member's right to have an Advance Directive in place is included in the Member Handbook. Information in the Member Handbook must include the

Back to Agenda Back to Item

Member's right to be informed by Contractor of State law regarding Advance Directives, and to receive information from Contractor regarding any changes to that law. Contractor must ensure that the following statement, or similar language provided by DHCS is included:

Advance care planning for Members enrolled in Medi-Cal palliative care in accordance with All Plan Letter (APL) 18-020, must include documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, Advance Directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms.

2) Information on Advance Directives must comply with all State and federal law requirements and must be updated to reflect any changes to laws governing Advance Directives.

3) Contractor must ensure its Network Providers, Subcontractors, and Downstream Subcontractors are trained on complying with valid Advance Directives in accordance with 42 CFR sections 422.128 and 438.3(j).

D. Interoperability Requirements for Member Records

Contractor must implement and maintain a Patient Access Application Programming Interface (API) as specified in 42 CFR section 431.60 as if such requirements applied directly to Contractor, and as set forth in APL 22-026. The Patient Access API must also meet the technical standards in 45 CFR section 170.215. Data maintained on or after January 1, 2016, must be made available to facilitate the creation and maintenance of a Member's cumulative health record.

1) At a minimum, Contractor must permit third-party applications to retrieve, with the approval and at the direction of the Member, the following Member records:

a) Adjudicated claims data from Contractor, and from any Subcontractors, Downstream Subcontractors and Network Providers, including claims data and cost data that may be Appealed, or are in the process of Appeal, Provider remittances, and Member cost-sharing pertaining to such claims, within (1) Working Day after a claim is processed;

b) Encounter Data, including Encounter Data from any capitated Subcontractors, Downstream Subcontractors, and Network Providers, within one (1) Working Day after receiving the data from Providers;

c) Clinical data, including diagnoses and related codes, and laboratory test results, within one (1) Working Day after the data is received by Contractor; and

d) Information about coverage for drugs administered in an outpatient setting as part of medical services, and updates to such information, including, if applicable, Member costs and any preferred drug list information, within one (1) Working Day after the effective date of any such information or updates to such information.

2) Contractor may deny or discontinue any third-party application's connection to an API if it reasonably determines, consistent with its security risk analysis under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule set forth in 45 CFR part 160 and 45 CFR part 164, subparts A and C, that continued access presents an unacceptable level of risk to the security of protected health information on its systems. The determination must be made using objective verifiable criteria that are applied fairly and consistently across all applications and developers, including but not limited to criteria that may rely on automated monitoring and risk mitigation tools.

E. Member Cost-Sharing Protections

1) Pursuant to The Social Security Act section 1932(b)(6) and 42 USC section 1396u-2(b)(6), Contractor and all of its Subcontractors must not hold a Member liable for any of the following:

a) Debts of Contractor in the event of Contractor's insolvency;

b) Payment for Covered Services provided by Contractor if Contractor has not received payment from DHCS, or if a Provider, under an agreement or other arrangement with Contractor, fails to receive payment from either DHCS or Contractor; or

Back to Agenda Back to Item

c) When payments to a Provider that furnishes Covered Services under an agreement or other arrangement with Contractor are in excess of the amount that normally would be paid by the Member if the service had been received directly from the Contractor.

2) Contractor, including its Network Providers and Subcontractors, must not bill a Member for any Covered Services provided under this Contract. Contractor must assure that all Network Provider Agreements include requirements whereby the Member must be held harmless for charges for any Covered Services.

3) Contractor and its Network Providers are prohibited from imposing on Members cost-sharing requirements. Contractor's Subcontractor Agreements and Network Provider Agreements must specify that a Provider agrees to accept Contractor's reimbursement as payment in full for services rendered to Members.

5.1.2 Member Services Staff

A. Contractor must employ and train a sufficient number of staff knowledgeable about Contractor's policies and procedures and capable of providing information to Members or Potential Members.

B. Contractor must ensure its Member services staff are trained and educated on all contractually required services for Members including policies and procedures on the scope of services required to be offered under this Contract, how to utilize services in the Medi-Cal program, how to access carved out services, and how obtain referrals to appropriate community resources and other agencies.

C. Contractor must ensure its Member services staff are educated on assisting Members with disabilities, chronic conditions, and components of Health Equity in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. *(Cultural and Linguistic Programs and Committees)*. This includes assisting Members with access barriers, disability access issues, referral to appropriate clinical services, Grievance and Appeal resolution, and State Hearings.

D. Contractor's Member services staff must refer Potential Members to the DHCS Enrollment broker when Potential Members request Enrollment with Contractor.

E. Contractor's Member services staff must refer Potential Members to their local county office for Medi-Cal eligibility determinations or redeterminations.

F. Contractor must ensure its Member services staff assist Members with a warm hand-off to Subcontractors and Downstream Subcontractors when Member services functions are delegated under a Subcontractor Agreement or Downstream Subcontractor Agreement.

5.1.3 Member Information

A. Contractor must provide all new Members, and Potential Members upon request, with information in compliance with 42 CFR section 438.10, Welfare and Institutions Code (W&I) section 14406, 22 CCR section 53895, and as set forth in this provision.

B. Contractor must provide information as required in 42 CFR section 438.10, W&I section 14406, and 22 CCR section 53895 no later than seven calendar days after the effective date of a Member's Enrollment.

C. Contractor must distribute the information required by Exhibit A, Attachment III, Subsection 5.1.3 *(Member Information)*, Paragraphs A-B annually, and upon a Member's request. Contractor must ensure the information is current and has prior approval for distribution from DHCS.

D. All Member Information must be in a format that is easily understood and in a font size no smaller than 12-point, in compliance with all requirements in 42 CFR sections 438.10, 438.404, and 438.408, W&I section 14029.91, and 22 CCR section 53876. Member Information is defined in this Contract and discussed in detail in APL 21-004. Member Information includes, but is not limited to, the Member Handbook (also called the Evidence of Coverage, or EOC), Provider Directory, and all mailings and notices critical to obtaining services, including form letters, Notices of Action (NOAs), NABDs, Grievances or Appeals, welcome packets, Marketing information, preventive health reminders, Member surveys, notices advising of the availability of free language assistance, and newsletters.

E. If a Member or Potential Member requests Member Information in a format other than as printed materials, Contractor must provide the Member Information in the alternate formats, including Braille, large-size print font no smaller than 20-point, accessible electronic format, or audio format.

Back to Agenda Back to Item

F. Contractor must ensure that all Member Information is provided to Members at a sixth grade reading level and approved by DHCS before distribution. Member Information must inform Members on Contractor's processes and the Member's right to make informed health decisions.

1) Contractor must submit to DHCS for review and approval their policy and process for collecting requests and disseminating materials in an alternative format when requested by Member.

2) For Members with disabilities, including visual impairment Contractor must provide Member Information in all Threshold Languages, alternative formats as specified by DHCS and in APL 21-004 and APL 22-002 (including Braille, large-size print font no smaller than 20-point, accessible electronic format, audio compact disc (CD) format, or data CD format), and through Auxiliary Aids at no cost and upon request. Contractor must provide Member Information in a timely fashion appropriate for the format being requested and taking into consideration the special needs of Members with disabilities or Limited English Proficiency (LEP) Members.

a) Contractor must inform Members who exhibit or mention difficulty reading print communications of their right to receive Auxiliary Aids and services, including alternative formats.

b) For Members who request an electronic alternative format to receive Member information, Contractor must inform the Member that, unless they request a password-protected format, the Member Information will be provided in an electronic format that is not password protected, which may make the information more vulnerable to loss or misuse. Contractor must clearly communicate to Members that they may request an encrypted electronic format with unencrypted instructions on how the Member can access the encrypted information.

c) Contractor must accommodate the communication needs of qualified individuals with disabilities, which may include communication with the Member's Authorized Representative (AR) or someone with whom it is appropriate for Contractor to communicate, such as a Member's disabled spouse. For these qualified individuals, Contractor must facilitate alternative format requests as identified in this

Back to Agenda Back to Item

Paragraph, as well as requests for other Auxiliary Aids and services.

3) Contractor must establish policies and procedures to ensure Members receive all Member Information in a Threshold Language or alternative format of their choice as required by 42 CFR section 438.10, W&I section 14029.91, and Exhibit A, Attachment III, Subsection 5.2.10.B (*Access Rights*).

4) Contractor must post a DHCS-approved nondiscrimination notice. Contractor must also post a notice with language taglines in a conspicuously visible font size in English, at least the top 15 non-English languages in the State, and any other languages, as determined by DHCS, explaining the availability of free language assistance services, including written translation and oral interpretation, and information on how to request Auxiliary Aids and services, including materials in alternative formats. The nondiscrimination notice and the notice with taglines must include Contractor's toll-free and Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) telephone number for obtaining these services, and must be posted as follows:

   a) In a conspicuous place in all physical locations where Contractor interacts with the public;

   b) In a location on Contractor’s website that is accessible on Contractor’s home page, and in a manner that allows Members, Potential Members, and members of the public to easily locate the information; and

   c) In the Member Handbook/EOC, and in all Member Information, informational notices, and materials critical to obtaining services targeted to Members, Potential Members, applicants, and the public at large, in accordance with APL 21-004 and APL 22-002, 42 CFR section 438.10(d)(2)-(3), and W&I section 14029.91(a)(3) and (f).

5) Contractor’s nondiscrimination notice must include all information required by W&I section 14029.91(e), any additional information required by DHCS, and must provide information on how to file a Discrimination Grievance with:

a) Both Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56; and

b) The United States Department of Health and Human Services (U.S. DHHS) Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability, per W&I section 14029.91(e)(5).

G. Member Information Noticing in Electronic Format

1) Contractor has the option to send Members a notice in Member welcome packets or annual informational mailings to inform Members of how to obtain their Provider Directory and Member Handbook electronically or in a paper version if preferred. The notice can be an insert, flyer, or other form of noticeable communication.

a) Contractor may provide Seniors and Persons with Disabilities (SPDs) a notice in lieu of a paper Member Handbook in Member welcome packets. Contractor must still provide all SPDs with the paper form of the Provider Directory. The paper form of the Provider Directory may be a personalized, shorter version of the full-sized Provider Directory.

b) Contractor may provide their non-SPD, dual eligible Members a notice on how to access the Provider Directory and Member Handbook electronically in lieu of a paper version in Member welcome packets.

c) Contractor may provide all Members, except SPDs, a notice in lieu of a paper Provider Directory and Member Handbook for annual informational mailings.

2) Prior to using a notice, Contractor must submit the following to DHCS for approval:

Back to Agenda Back to Item

a) A written proposal on Contractor's letterhead addressed to "DHCS Contract Manager" requesting to use a notice instead of mailing the informing materials. The proposal must include the following:

   i. An overview of Contractor's process for utilizing the notice and how Contractor will meet all notice requirements.

   ii. An explanation of the notice's purpose, including a description of the Member population(s) who will receive the notice.

   iii. Time frame for implementation.

   iv. A statement that Contractor is complying with all applicable State and federal laws, the requirements of this Contract, and other DHCS guidance, including APLs and Policy Letters (PLs).

   v. For Member packages only, a proposal of how Contractor will move toward creating a personalized Provider Directory, with a timeline included that covers the cycle of production to delivery of personalized Provider Directories.

   vi. Any other pertinent information necessary for DHCS to review.

b) A written policy and procedure describing in detail the process Contractor will utilize for the notice and how Contractor will continue to meet all language and format requirements set forth in 42 CFR section 438.10(d)(3), Provider Directory and website requirements in accordance with 42 CFR section 438.10(h), and sub-contractual relationship and delegation requirements set forth in 42 CFR section 438.230.

c) A sample of Contractor's proposed notice regarding electronic communications. The notice must be easily identifiable by the Member, state the purpose of each piece of Member material offered, and identify the options Members will have for receiving their Member materials.

3) The notice must be compliant with all the requirements of this Contract and DHCS policy, and federal and State statutes and regulations on Member Information, including 42 CFR sections 438.10 and 438.404, and W&I section 14029.91. DHCS will approve Contractor's notices on a case-by-case basis.

4) DHCS reserves the right to require Contractor to revert to sending printed copies of the Provider Directory and Member Handbook to its Members, at any time.

H. Provider Directory

1) Contractor must submit its complete Provider Directory to DHCS for review and approval prior to initial operations.

2) Contractor must make its Provider Directory available to all Members and to DHCS for distribution as required.

3) Contractor's Provider Directory must be available in both paper and electronic formats. Provider Directory information must be included with Contractor's written Member Information for new Members, and thereafter available upon request. An electronic Provider Directory must be posted on Contractor's website in a machine readable and accessible file and format.

4) Contractor must update and submit its paper and electronic Provider Directories to DHCS in accordance with 42 CFR section 438.10(h)(3)(i)(A)-(B). Contractor must submit under the following timelines:

a) A paper Provider Directory must be updated at least monthly, if Contractor does not have a mobile-enabled, electronic Provider Directory; or quarterly, if Contractor has a mobile-enabled, electronic Provider Directory; and

b) An electronic Provider Directory must be updated no later than one week after Contractor receives updated provider information.

5) Contractor's Provider Directory submission must include complete, accurate and updated Provider Directory and Network information and data and submit as required by 42 CFR section 438.10(h)(3). Contractor's Provider Directory must also comply with all

Back to Agenda Back to Item

requirements in PL 11-009. DHCS is authorized to require changes or corrections to Contractor's Provider Directory at any time.

6) Contractor must implement and maintain a publicly accessible standards-based Provider Directory API, as described in 42 CFR section 431.70 and APL 22-026, which must include the information required here in Exhibit A, Attachment III, Subsection 5.1.3.H (*Member Information*). The Provider Directory API must meet the technical standards in 45 CFR section 170.215, excluding the security protocols related to user authentication and authorization.

7) Provider Directories must comply with 42 CFR section 438.10(h) and H&S section 1367.27, and must include the following information for in-Network PCP, Specialists, hospitals, Enhanced Care Management (ECM), Community Support Providers, Behavioral Health Providers, and any other Providers (e.g., Community Health Workers (CHW)) contracted for Medi-Cal Covered Services:

   a) The Provider's or site's location name and any group affiliation(s), National Provider Identifier (NPI) number, street address(es), all telephone numbers associated with the practice site, and, if applicable, website URL for each Service Location;

   b) Provider's specialty type and paneling status that allows them to treat specific populations, including but not limited to, whether they are a California Children's Services (CCS paneled provider;

   c) Whether the Provider is accepting new patients;

   d) Information on the Provider's affiliated medical group or Independent Physician/Provider Associations (IPA), NPI number, address, telephone number, and, if applicable, website URL for each Physician Provider of affiliated group or IPA;

   e) The hours and days when each Service Location is open, including the availability of evening or weekend hours;

   f) The services and benefits available, including accessibility symbols approved by DHCS confirming whether the office/facility (exam room(s), equipment, etc.) can

Back to Agenda Back to Item

accommodate Members with physical disabilities as required by PL 11-009;

g) The Provider's cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered either by the Provider or a skilled medical interpreter at the Provider's facility;

h) The telephone number to call after normal business hours;

i) Identification of Network Providers or sites that are not available to all or new Members

j) The link to the Medi-Cal Rx Pharmacy Locator, which can be found on the dedicated Medi-Cal Rx website described in APL 22-012.

I. Member Handbook

Contractor must comply with the requirements in 22 CCR section 53895(b) by distributing a Member Handbook, also known as an Evidence of Coverage and Disclosure Form (EOC/DF) to each Member and to Potential Members, upon request. The Member Handbook must meet all requirements in 42 CFR section 438.10(g), 22 CCR section 53881, and any other requirements in State and federal law, and this Contract. In addition, the Member Handbook must meet all applicable requirements contained in 42 CFR section 438.10(d), W&I section 14029.91, 22 CCR section 53876 for Limited English Proficiency (LEP) Members and Potential Members and H&S section 1363 as to translation, print size, readability, and understandability of text.

1) Contractor must provide to each Member, or Member's family unit, a Member Handbook that constitutes a full and fair disclosure of the Member's right to obtain and Contractor's provision of all Medi-Cal services that are available and accessible to the Member. Contractor must post its most recent Member Handbook to its website.

2) Contractor must use the DHCS template for its Member Handbook. Contractor must submit its information that is specific to Contractor, where applicable. Contractor must submit its completed Member Handbook, with all Contractor-specific information included in redline, for review and approval by DHCS before distribution to Members.

Back to Agenda Back to Item

3) Contractor must make the revised Member Handbook available to Members based on the timeframes required by State and federal law and at any time DHCS, a Member, or a Potential Member requests a copy.

4) Although Contractor is required to use the DHCS Member Handbook template, Contractor remains solely responsible for ensuring that Members receive the following information through the Member Handbook:

   a) Contractor's name, address, toll-free telephone number(s) for Member services, Medi-Cal Rx telephone number(s) and website information, any other Contractor staff providing services directly to Members, and information on Contractor's Service Area;

   b) Information on how to access services in the Medi-Cal managed care system, including a description of the full amount, duration, and scope of Covered Services and how to obtain services under this Contract. The Member Information must also include information on services that require Prior Authorization and how to request it, health education and how to access appropriate community resources and other agencies, interpretive services provided by Contractor's staff and at service sites, and an explanation of "carved- out" services, including Specialty Mental Health Services, and any service limitations and exclusions from coverage or charges for services. The Member Handbook must also include information on services to which Contractor, Subcontractor, Downstream Subcontractor, or a Network Provider may have a moral objection to perform or support and alternative methods for obtaining those services;

   c) Procedures for accessing Covered Services, which explain that Covered Services will be obtained through Contractor's Network Providers unless otherwise allowed under this Contract;

   d) A description of the Member identification card issued by Contractor, if applicable, and an explanation of its use in authorizing or assisting Members in obtaining services;

e) Procedures for selecting or requesting a change in PCP at any time, any requirements for a Member to change their PCP, reasons for which a request for a specific PCP may be denied, and reasons why a PCP may request a change;

f) The purpose and value of scheduling and completing an Initial Health Appointment (IHA);

g) The availability and procedures for obtaining after-hours services 24 hours a day, seven days a week, including the appropriate Network Provider locations and telephone numbers to obtain services. This must include an explanation of the Members' right to interpretive services, at no cost, to assist in receiving after-hours services;

h) Definition of what constitutes an Emergency Medical Condition, Emergency Services, and post-stabilization services. The Member Handbook must expressly state that Prior Authorization is not required to receive Emergency Services and include the use of 9-1-1 for obtaining Emergency Services;

i) The right to receive Emergency Services in any hospital or other setting, and procedures for obtaining Emergency Services from specified Network Providers or from out-of-Network Providers, including Emergency Services outside of Contractor's Service Area. This includes the right to the provision of at least a 72-hour supply of Medically Necessary medication in an emergency situation is provided;

j) Process for referral to Specialists, including an explanation of the Prior Authorization process, in sufficient detail so the Member can understand how the process works, including authorization and referral timeframes and alternative access standards as required by W&I section 14197.04, APL 23-001, and APL 21-011;

k) Procedures for obtaining Emergency Medical Transportation (EMT) and Non-Emergency transportation services to service sites that are offered by Contractor or available through the Medi-Cal program, and how to obtain such services. Include a description of medical transportation, including EMT, Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) services, and

Back to Agenda Back to Item

how Contractor coordinates access to appropriate transportation, when needed;

l) The right to file a Grievance and request an Appeal with Contractor, and procedures for filing either orally, in writing, or over the phone. Contractor must inform Members of all Appeal and State Hearing rights when it makes a decision to deny, delay or modify a Member's request for services as set forth in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

m) Information on disenrollment from Contractor. Contractor must ensure that the following information is included:

i. The causes for which a Member may lose eligibility to receive services under this Contract as set forth in Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*), and the procedures for disenrollment due to the loss of eligibility.

ii. An explanation of the expedited disenrollment process for Members qualifying under conditions specified under 22 CCR section 53889(j), which includes Children receiving services under the Foster Care or Adoption Assistance Programs, Members who require out-of-Network transplant services if they are unavailable in-Network, and Members already enrolled in another Medi-Cal, Medicare, or commercial managed care plan.

n) An explanation of the Member's right to disenroll at any time, and reenroll in the competing Medi-Cal managed care plan in the county (in counties where another Medi-Cal managed care plan is available), subject to the requirements in 22 CCR 53889, 22 CCR 53891(c) and any restricted disenrollment period;

o) Information on the Member's right to a Medi-Cal State Hearing, the process for obtaining a State Hearing, the timeframe to request a State Hearing, and the rules that govern representation in a State Hearing. Contractor must ensure the following information is included:

i. The circumstances under which an expedited State Hearing is possible;

ii. Information stating that Contractor will assist in completing the State Hearing request when a health care service requested by the Member or Provider has been denied, delayed, or modified, as required by APL 21-011;

iii. The timelines which govern a Member's right to a State Hearing, pursuant to W&I section 10951 and for an expedited State Hearing pursuant to W&I section 10951.5;

iv. The Department of Social Services (DSS) Public Inquiry and Response Unit toll-free telephone number (1-800-952-5253) to request a State Hearing; and

v. Contractor's obligation to continue the disputed service(s) until there is a final decision on the State Hearing as long as if the Member requests a State Hearing in the specified timeframe(s) as required by 42 CFR section 438.420.

p) The availability of, and procedures for obtaining services at FQHCs, RHCs and IHCPs;

q) The Member's right to seek family planning services from any qualified family planning Provider in the Medi-Cal program, including out-of-Network Providers; how to access these services; that a referral is not necessary; and a description of the limitations on the services that Members may seek out-of-Network. The DHCS Office of Family Planning toll-free telephone number (1-800-942-1054) that provides consultation and referral to family planning clinics must also be included. Contractor must ensure that the following statement, or similar language provided by DHCS is included:

Family planning services are provided to Members of childbearing age to enable them to determine the number and spacing of Children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, you pick a doctor who is

Back to Agenda Back to Item

located near you and will give you the services you need. Our Primary Care Providers and OB/GYN Specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with [Plan Name] without having to get permission from [Plan Name]. [Plan Name] will pay that doctor or clinic for the family planning services you get.

r) Procedures for providing female Members with direct access to an in-Network women's health Specialist for women's preventive and routine health care services without requiring Prior Authorization. Access to a women's health Specialist must be provided in addition to the Member's designated PCP if the PCP is not a women's health Specialist;

s) Information on the availability of and procedures for obtaining Certified Nurse Midwife (CNM) and Nurse Practitioner services, pursuant to Exhibit A, Attachment III, Subsection 5.2.8.G. (*Specific Requirements for Access to Programs and Covered Services*);

t) Information on how to access the DHCS Medi-Cal Managed Care Ombudsman Program and toll-free telephone number (1-888-452-8609), and the DMHC HMO Consumer Service toll-free telephone number (1-800-400-0815) for resolution of Member concerns and complaints;

u) Information on the provision and availability of services covered under the California Children's Services (CCS) Program from out-of-Network Providers, and how to access CCS Program;

v) **Information on how to obtain Minor Consent Services through Contractor's Network, an explanation of those services, and information on how Minor Consent Services can also be obtained from out-of-Network Providers without requiring Prior Authorization;**

w) Information on the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for Members less than 21 years of age, and that it includes all Medically Necessary health care, diagnostic services, treatments, and other measures listed in 42 United States Code (USC) section 1396d(a) and (r), whether or not covered under the

Back to Agenda Back to Item

California Medicaid State Plan. All EPSDT services are Covered Services unless expressly excluded under this Contract;

x) An explanation on how to use the Medi-Cal Fee-For-Service (FFS) system when Medi-Cal services are excluded or limited under this Contract, and how to obtain additional information;

y) An explanation that an American Indian Member's status as a Member is voluntary and that an American Indian Member cannot be required to enroll in a Medi-Cal managed care plan and has the right to access IHCP, choose an IHCP within Contractor's Network as a PCP, and disenroll from Contractor at any time, without cause;

z) Language regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor, pursuant to H&S section 7158.2. This information must be provided in the Member Handbook as well as Contractor's newsletter and any other direct communication with Members, and must be provided the Members annually under H&S section 7158.2;

aa) Confirmation of whether Contractor offers financial bonuses or other incentives to its Network Providers. This information must inform the Member of the right to request additional information about these bonuses or incentives from Contractor, their Network Provider, or the Network Provider's medical group or IPA, pursuant to H&S section 1367.10;

bb) Instructions on how a Member can request a copy of, or the website link to locate, Contractor's non-proprietary clinical and administrative policies and procedures;

cc) That oral interpreter services are available for any language spoken by the Member, and that the Member can inform Contractor of their preferred language to receive written translations of Member materials in the identified Threshold Languages, both free of charge, with instruction on Contractor's obligations to ensure these services are provided;

dd) That Auxiliary Aids and services are available upon request and at no cost for Members with disabilities, and how to access these services;

ee) Information on how to report suspected Fraud, Waste and Abuse; and

ff) Information on how to request Community Supports.

J. Member Identification Card

Contractor must provide an identification card to each Member, which identifies the Member and authorizes them to access Covered Services. The card must inform the Member that they may seek Emergency Services from out-of-Network Providers. The card must inform the Member of the Medi-Cal Rx telephone number. The Member identification card must also inform the Member that Emergency Services are covered by Contractor without Prior Authorization, and at no cost to the Member.

5.1.4 Primary Care Provider Selection

A. Contractor must implement and maintain DHCS-approved procedures to ensure that each new Member who is not enrolled in comprehensive Other Health Coverage (OHC) has an appropriate and available PCP. Comprehensive OHC refers to:

1) Members with the OHC Code indicator C, H, F, K, or P as listed in the 834 file, or,

2) OHC with a scope of coverage of at least Outpatient, Inpatient, and Medical/Allied (OIM) Services found in positions 119 through 126 in the Health Insurance System Database (HISDB) file.

B. Contractor must provide each new Member an opportunity to select a PCP within the first 30 calendar days of Enrollment. Contractor must make best efforts to ensure the Member is assigned to the PCP the Member selected at the time of their Enrollment, unless the PCP is unavailable or is not accepting new patients.

C. If the Member does not select a PCP within 30 calendar days of the effective date of Enrollment, Contractor must assign that Member to a PCP and notify the Member and the assigned PCP no later than 40 calendar days after the Member's Enrollment. Contractor must ensure that adverse selection does not occur when Members are assigned to PCPs.

1) Contractor must allow Members to select a clinic that provides Primary Care in lieu of selecting a specific PCP, where available.

2) If Contractor's Network includes Nurse Practitioners (NP), Certified Nurse Midwives (CNMs), OB-GYN, or Physician Assistants, the Member may select one of these practitioners as their PCP within 30 calendar days of Enrollment to provide Primary Care services in accordance with 22 CCR section 53853(a)(4).

3) SPD Members may select a Specialist or clinic as a PCP if the Specialist or clinic agrees to serve as the Member's PCP and is qualified to treat the health conditions of the SPD Member, in accordance with W&I section 14182(b)(11).

4) Contractor must ensure that Members are allowed to change their PCP, NP, CNM, or Physician Assistant assignment, upon request, by selecting a different PCP from Contractor's Network.

D. Contractor must inform Members through direct outreach to provide an explanation for the reason the Member could not be assigned to their selected PCP.

E. Contractor must ensure that Members who have an established relationship with a Network Provider, and who want to continue their patient-Provider relationship, are assigned to that Provider without disruption in the Member's care if the Member's existing relationship meets the requirements set forth in APL 18-008 (revised).

F. Contractor must ensure that Members can choose Traditional and Safety-Net Providers as their PCP, and that American Indian Members may choose an IHCP within Contractor's Network as their PCP.

G. Contractor is not obligated to require full benefit dual eligible Members to select a Medi-Cal PCP. Nothing in this section must be construed to require Contractor to pay for services that would otherwise be paid for by Medicare.

H. If a Member does not select a PCP within 30 calendar days of the effective date of Enrollment, Contractor must use utilization data or other data sources in its possession or provided by DHCS to select a PCP for the Member. This includes review of electronic data to confirm existing Provider relationships for the purpose of PCP assignment, including a Specialist or clinic for an SPD if they have indicated they have a

Back to Agenda Back to Item

preference for either to act as their PCP. Contractor must comply with all federal and State privacy laws in the provision and use of this data.

I. Contractor must notify the PCP that a Member has selected or been assigned to the Provider within ten calendar days from the date selection or assignment is complete.

J. Contractor must maintain procedures that proportionately include contracting with Traditional and Safety-Net Providers in the assignment process for Members who do not choose a PCP. Contractors in public hospital health system counties must assign PCPs in compliance with W&I section 14199.1.

5.1.5 Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests

Contractor must notify Members of a decision to deny, defer, or modify requests for Prior Authorization, in accordance with 42 CFR section 438.210(c) and 22 CCR sections 51014.1 and 53894 by providing a NOA to Members and/or their AR, regarding any denial, deferral, or modification of a request for approval to provide a health care service. This notification must be provided in accordance with all requirements set forth in Exhibit A, Attachment III, Subsection 4.6.4 (*Notice of Action*).

Exhibit A, ATTACHMENT III

5.2 Network and Access to Care

5.2.1 Access to Network Providers and Covered Services
5.2.2 Network Capacity
5.2.3 Network Composition
5.2.4 Network Ratios
5.2.5 Network Adequacy Standards
5.2.6 Access to Emergency Service Providers and Emergency Services
5.2.7 Out-of-Network Access
5.2.8 Specific Requirements for Access to Programs and Covered Services
5.2.9 Network and Access Changes to Covered Services
5.2.10 Access Rights
5.2.11 Cultural and Linguistic Programs and Committees
5.2.12 Continuity of Care for Seniors and Persons with Disabilities
5.2.13 Network Reports
5.2.14 Site Review
5.2.15 Street Medicine

5.2 Network and Access to Care

5.2.1 Access to Network Providers and Covered Services

A. Primary Care

1) Contractor must ensure that each Member has an assigned Primary Care Provider (PCP) who is available and physically present at the Service Location for sufficient time to ensure access and appointments for the assigned Member when medically required. This requirement does not preclude an appropriately licensed Provider from being a substitute for the Member's assigned PCP in the event of vacation, illness, or other unforeseen circumstances.

2) Contractor must have processes in place to assist Members in selecting PCPs who are accepting new patients.

3) Contractor must consider the requirements in Welfare and Institutions Code (W&I) section 14182(b)(11) when assigning Members who are Seniors and Persons with Disabilities (SPD) to a PCP. Additionally, Contractor must ensure that Members have the option of selecting an Indian Health Care Provider (IHCP), Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC), as their PCP, where available.

B. Specialists

1) Contractor must ensure that Members have access to Specialists for Medically Necessary Covered Services in accordance with W&I section 14197, 22 CCR section 53853, and 28 CCR section 1300.67.2.2.

2) Contractor must maintain an adequate Network that includes adult and pediatric Specialists, and at a minimum, the core Specialists required in W&I section 14197(h)(2), within its Network to ensure Medically Necessary specialty care is available in accordance with 22 CCR section 53853(a), and W&I sections 14182(c)(2) and 14197.

C. Contractor must ensure its Network Providers, Subcontractors, and Downstream Subcontractors have adequate Networks and staff within its Service Area, including Physicians, nurses, and administrative and other support staff to ensure that they have sufficient capacity to provide and

coordinate care for Covered Services are provided in accordance with W&I section 14197, 22 CCR section 53853, 28 CCR section 1300.67.2.2, and all requirements in this contract.

D. Contractor must monitor Subcontractors and Downstream Subcontractors to ensure they can adequately deliver culturally and linguistically competent care including offering interpreter services when a Limited English Proficient (LEP) Member accesses a Provider who does not speak the Member's language.

E. Contractor must ensure that Members have access to all Non-specialty Mental Health and Substance Use Disorder (SUD) Covered Services in accordance with 42 Code of Federal Regulations (CFR) section 438.900 *et seq.* Contractor must coordinate care for all Specialty Mental Health Services (SMHS) and SUD services and provide referrals including mechanisms to track completion of follow up visits, to the county mental health plan (MHP) and Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services as outlined in Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*)

5.2.2 Network Capacity

A. Contractor must maintain a Network adequate to provide the full scope of benefits to 60 percent of all Potential Members or current Member Enrollment, whichever is higher, within its Service Area. Contractor must increase the capacity of the Network as necessary to accommodate all Enrollment growth beyond the 60 percent.

B. Contractor may request to renegotiate its Network capacity requirement with DHCS if utilization by Contractor’s Members does not exceed 75 percent of the required Network capacity, after the first 12 months of operation. Any such change is subject to DHCS review and approval.

5.2.3 Network Composition

A. Contractor must maintain an adequate Network within its Service Area, in compliance with W&I section 14197, and if necessary to ensure contract compliance with Network adequacy. Contractor may offer to contract with Providers in adjoining Service Areas but must make good faith efforts to contract with Providers within Contractor’s Service Area. Contractor’s Network must include at a minimum adult and pediatric PCPs, obstetrics, and gynecology (OB/GYNs), adult and pediatric Behavioral Health Providers, adult and pediatric Non-specialty outpatient Mental Health Service (NSMHS) Providers, adult and pediatric Specialists, hospitals, and

Long-Term Care (LTC) Providers to ensure adequate access to all Medically Necessary Covered Services for all Members and to meet all Network adequacy requirements.

B. Contractor must maintain an adequate Network of Allied Health Personnel, supportive paramedical personnel, public hospitals and health care systems, care navigators, caseworkers, and public health nurses, and an adequate number of accessible service sites to ensure adequate access to all Medically Necessary Covered Services for all Members.

C. Contractor must include in its Network, where available, IHCP, FQHC, RHCs, Freestanding Birthing Centers (FBC), Certified Nurse Midwives (CNMs), and Licensed Midwives (LM) in accordance with W&I section 14087.325, Medicaid State Health Official Letter #16-006, All Plan Letter (APL) 18-022, and APL 23-001.

1) If Contractor is a local initiative health plan model, it must offer to contract with all FQHCs and RHCs in its county(ies), in accordance with W&I section 14087.325. Local initiative health plans must maintain and provide supporting documentation of all contracting efforts with each FQHC and RHC in its county(ies) to DHCS upon request, even if Contractor has a minimum of one active contract with an FQHC and RHC in their county(ies).

2) If Contractor is not a local initiative health plan model, it must contract with a sufficient number of and include at least one FQHC, one RHC, and one FBC in the Network, where available in Contractor's Service Area(s), to the extent that the FQHC, RHC, and FBC Providers are licensed and recognized under State law.

D. Contractor must offer to contract with all IHCP available in each county(ies) in which Contractor operates in accordance with 22 CCR section 55120. If Contractor is unable to contract with an IHCP, Contractor must allow eligible Members to obtain services from out-of-Network IHCP in accordance with 42 CFR section 438.14.

E. Contractor must make good faith efforts to contract with at least one cancer center within their Networks and subcontracted Networks, if applicable, within each county in which Contractor operates for the provision of Covered Services to any eligible Member diagnosed with complex cancer diagnosis in accordance with W&I section 14197.45.

F. Contractor must continually ensure that the composition of its Network meets the ethnic, cultural, and linguistic needs of Contractor's Members.

G. Contractor must have an adequate number of NSMHS Providers to provide Medically Necessary, NSMHS based on current and anticipated utilization trends for its Members.

H. Contractor must include in its Network any traditional and Safety-Net Provider that is willing to contract under the same terms and conditions that Contractor offers to any other similar Provider in accordance with 22 CCR section 53800(b)(2)(C)(1).

I. Contractor must ensure that every LTC Provider in its Service Area that is licensed by the California Department of Public Health (CDPH) as a qualified LTC Provider is included in Contractor's Network, to the extent that the LTC Provider remains licensed, certified, operating, and is willing to enter into a Network Provider Agreement with Contractor on mutually agreeable terms and meets Contractor's Credentialing and quality standards. If Contractor determines that additional LTC Providers are necessary to meet the needs of its Members, Contractor must offer to contract or enter into a letter of agreement with any additional CDPH licensed LTC Providers in its Service Area or in adjoining Service Areas.

J. Contractor must receive a preapproval or assessment of suitability from CDPH prior to the execution of a Network Provider Agreement for LTC Providers undergoing a change of ownership. Network Provider Agreements must have a clause that LTC Providers must notify Contractor if it is undergoing a change of ownership so Contractor can obtain preapproval or assessment of suitability from CDPH.

K. Contractor must ensure that every CBAS Provider within Contractor's Service Area, that has been approved by the California Department of Aging (CDA) as a CBAS Provider, is included in Contractor's Network to the extent that the CBAS Provider remains licensed as an Adult Day Health Care (ADHC) Center, is certified and enrolled as a Medi-Cal Provider, is willing to enter into a Network Provider Agreement with Contractor on mutually agreeable terms, and meets Contractor's credentialing and quality standards. Contractor must contract with a sufficient number of Community-Based Adult Service (CBAS) Providers to timely meet the needs of Members who are CBAS-eligible. Contractor must have an adequate number of CBAS Providers that are geographically located within one hour's transportation time of its CBAS-eligible Members and that are appropriate for and proficient in addressing CBAS-eligible Members' specialized health needs and acuity, communication, cultural, and language needs and preferences. Contractor must also meet expected CBAS-utilization without a waitlist.

Back to Agenda Back to Item

5.2.4 Network Ratios

A. Contractor must continually comply with 22 CCR sections 53853(a)(1) - (2) and ensure that its Network meets the following full-time equivalent (FTE) Physician to Member ratios:

1) FTE Primary Care Providers that are Physicians: Member 1:2,000

2) FTE Total Physicians: Member 1:1,200

B. Contractor must ensure that FTE non-physician medical practitioner's Member caseload does not exceed 1,000 patients in accordance with 22 CCR section 53853(a)(3).

C. Contractor must ensure compliance with 22 CCR sections 51240 and 51241, and Business and Professions Code sections 3516 and 2836.1. Contractor must ensure full-time equivalent Physician supervisor to non-physician medical practitioner ratios do not exceed the following:

1) Physician Supervisor: Nurse Practitioners 1:4

2) Physician Supervisor: Physician Assistants 1:4

3) A Physician supervisor may not supervise more than four non-physician medical practitioners in any combination.

5.2.5 Network Adequacy Standards

A. Timely Access

1) Contractor must continuously monitor and enforce Network Providers', Subcontractors', and Downstream Subcontractors' compliance with the requirements in W&I section 14197(d)(1)(A), 28 CCR section 1300.67.2.2, and the requirements in this Contract.

2) Contractor must develop, implement, and maintain procedures to monitor and ensure that Contractor, Network Providers, Subcontractors, and Downstream Subcontractors:

a) Comply with requirements for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, Children's preventive periodic health assessments, and adult Initial Health Appointments (IHAs) in accordance with W&I section 14197, and 28 CCR section 1300.67.2.2:

i. Urgent Care appointment for services that do not require Prior Authorization within 48 hours of a request;

ii. Urgent Care appointment for services that do require Prior Authorization within 96 hours of a request;

iii. Non-urgent appointments for Primary Care within ten (10) business days of request;

iv. Non-urgent appointments with Specialists within 15 business days of request;

v. Non-urgent appointment with a non-physician mental health Provider with ten (10) business days of request;

vi. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, or illness within 15 business days of request;

vii. Availability of LTC Providers for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara within five (5) business days of request;

viii. Availability of LTC Providers for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura within seven (7) business days of request; and

ix. Availability of LTC Providers for the following counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera,

Back to Agenda Back to Item

Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba within 14 business days of request.

b) Offer Members appointments for Covered Services within a time frame appropriate for their health condition but no longer than the appointment timeframes set forth in 28 CCR section 1300.67.2.2, unless the Member's preference is to wait for a later appointment from a specific Network Provider. The applicable waiting time for a particular appointment may be extended if the following conditions are met:

i. The Member's Medical Record notes that waiting will not have a detrimental impact on the Member's health, as determined by the referring or treating licensed health care Provider, or by the health professional providing triage or screening services, who is acting within the scope of their practice consistent with professionally recognized standards of practice;

ii. The Provider's decision to extend the applicable waiting time is noted in the Member's Medical Record and made available to DHCS upon request; and

iii. Contractor ensures that the Member receives notice of the Provider's decision to extend the applicable waiting time with an explanation of the Member's right to file a Grievance disputing the extension.

c) Contractor must provide the appointment time standards to Network Providers, Subcontractors, and Downstream Subcontractors, and monitor appointment waiting times in Network Providers' offices pursuant to 42 CFR section 438.206, W&I section 14197, and 28 CCR section 1300.67.2.2. Contractor must also ensure that Network Providers comply with requirements for follow up on missed appointments;

d) Offer hours of operation to Members that are no less than the hours of operation offered to non-Medi Cal patients, or to Medi-Cal Fee-For-Service (FFS) beneficiaries if the Network Provider serves only Medi-Cal beneficiaries; and

e) Maintain procedures for triaging Members' telephone calls, providing telephone medical advice, and accessing telephone interpreters 24 hours a day, seven days a week.

3) During normal business hours, the waiting time for a Member to speak by telephone with Contractor's customer service representative must not exceed ten minutes.

4) Contractor must ensure its customer service representatives have knowledge and competency to assist in resolving Members' questions and concerns.

5) Contractor must have a medical director or licensed Physician acting on behalf of Contractor's medical director, who is available 24 hours a day, seven days a week to assist with access issues.

6) Contractor must ensure that its Network Providers, Subcontractors, and Downstream Subcontractors participate in all timely access survey(s) and Network adequacy activities conducted by DHCS or its contractors. Contractor entering into new or amended Network Provider or Subcontractor agreements with Network Providers, Subcontractors, and/or Downstream Subcontractors must include language requiring Provider participation.

B. Time or Distance

1) Contractor must ensure that its Network Providers, Subcontractors, and Downstream Subcontractors meet the time or distance standards for adult and pediatric PCPs, adult and pediatric core Specialists, OB/GYN primary and specialty care, adult and pediatric mental outpatient health Providers, and hospitals, as required by W&I section 14197(b) and (c).

2) Contractor must either exhaust all other reasonable options for contracting with Providers, including offering to contract with Providers in adjoining Service Areas, or provide evidence to DHCS demonstrating that its delivery structure is capable of delivering the appropriate level of care and access as required by W&I section

Back to Agenda Back to Item

14197 prior to submitting an Alternate Access Standard (AAS) request to DHCS.

3) If Contractor is unable to comply with the time or distance standards set forth in W&I section 14197, Contractor must submit an AAS request to DHCS for review and approval in accordance with APL 23-001, detailing how it intends to arrange for Covered Services in accordance with W&I section 14197(e)(3).

4) Contractor must publish on its website its approved AAS requests in accordance with W&I section 14197.04.

5) If Contractor has received an AAS approval from DHCS for a core Specialist, upon a Member's request, Contractor must assist the Member in obtaining an appointment with the appropriate core Specialist in accordance with W&I section 14197.04. Contractor must either make its best effort to establish a Member-specific case agreement with an out-of-Network Provider or arrange for an appointment with a Network Provider in an adjoining Service Area within the time or distance standards in accordance with W&I section 14197.04. If needed, Contractor must assist in arranging transportation for the Member. Contractor must not be held liable for fulfilling these requirements if either there is no core Specialist within the time or distance standards of this Contract, or the core Specialist has refused to contract in the previous 12 months.

6) Contractors that do not meet time or distance standards without the use of an AAS request must provide documentation demonstrating efforts to recruit new Providers to these areas. Contractor must submit this documentation as part of the Network certification report detailed in 5.2.13.

5.2.6 Access to Emergency Service Providers and Emergency Services

A. Contractor must have within its Network, at a minimum, a designated Emergency Services facility, providing care 24 hours a day, seven days a week. This designated Emergency Services facility must have one or more Physicians and one nurse on duty in the facility at all times.

B. Contractor must ensure that Members with Emergency Medical Conditions are seen on an emergency basis and that Emergency Services are available and accessible within Contractor's Service Area seven days a week, 24 hours a day, in accordance with 42 USC sections 1395dd and

Back to Agenda Back to Item

1396u-2(b)(2), 42 CFR sections 438.114 and 438.206(c)(1)(iii), and 28 CCR 1300.67(g)(1).

C Contractor must reimburse the costs of Emergency Services without Prior Authorization pursuant to 42 USC section 1395dd, 42 CFR section 438.114, 28 CCR section 1300.67(g), and 22 CCR section 53216 and 53855.

D. Contractor must have a medical director or licensed physician acting on behalf of Contractor's medical director, who is available 24 hours a day, seven days a week to authorize Medically Necessary Post-Stabilization Care Services, to respond to hospital inquiries within 30 minutes, and to coordinate the transfer of a Member whose Emergency Medical Condition is stabilized.

E. Contractor must ensure that Members have timely access to Medically Necessary follow-up care including but not limited to appropriate referrals to Primary Care, Behavioral Health Services, and social services for Members who have been screened in the emergency room and do not require Emergency Services.

F. Contractor must coordinate access to Emergency Services in accordance with Contractor's DHCS-approved emergency department protocol, as required in Exhibit A, Attachment III, Section 3.2 (*Provider Relations*).

G. If Contractor delegates its Emergency Services and Post-Stabilization Care Services oversight obligations to Network Providers, Subcontractors, or Downstream Subcontractors, it must ensure a licensed physician is available seven days a week, 24 hours a day, to authorize Medically Necessary Post-Stabilization Care Services and coordinate the transfer of stabilized Members in an emergency department to an appropriate Network Provider, if necessary, as required under Health & Safety Code (H&S) section 1371.4.

5.2.7 Out-of-Network Access

A. Contractor must authorize and arrange for out-of-Network access in the following circumstances:

1) Contractor does not meet Network adequacy requirements set forth in W&I section 14197;

2) Contractor does not have an AAS approved by DHCS and fails to meet the Network adequacy standards set forth in W&I section 14197;

3) Contractor fails to comply with the requirements for timely access to appointments; or

4) Contractor must arrange for access to out-of-Network LTC when Medically Necessary for a Member in cases where Contractor does not have in-Network LTC capacity.

B. Contractor must authorize and arrange for services from out-of-Network Providers when the Provider type is unavailable within the Network but available in an adjoining county(ies). If there is no Network Provider in the adjoining county(ies), Contractor must authorize out-of-Network services to the most appropriate Provider as close to time or distance requirements as possible.

C. Contractor must provide Non-Emergency Medical Transportation (NEMT) or Non-Medical Transportation (NMT) to the out-of-Network Provider, at no cost to the Member. Contractor must inform Members of their right to obtain NEMT or NMT services to access out-of-Network services in accordance with W&I section 14197.04.

D. Contractor must adequately and timely cover and reimburse Providers for out-of-Network services rendered to its Members for as long as Contractor is unable to provide these services in its Network. Contractor must ensure that the Member is not charged for services furnished out-of-Network. Contractor must also ensure that Members are not balance-billed for any service provided out-of-Network.

5.2.8 Specific Requirements for Access to Programs and Covered Services

A. Family Planning Services

1) Contractor must ensure Members have access to family planning services through any available family planning Provider regardless of whether they are in or out of the Network, without requiring Prior Authorization. Contractor must provide family planning services in a manner that ensures Members have the freedom to choose their preferred method of family planning consistent with 42 CFR section 441.20.

2) Contractor must not restrict a Member's Provider choice for family planning services covered pursuant to 42 CFR section 431.51(a)(3) and W&I section 14132.07.

3) Contractor's Member Handbook must inform Members of their right to access any qualified family planning Provider regardless of whether the Provider is in the Network and without Prior Authorization, in addition to requirements included in Exhibit A, Attachment III, Section 5.1 (*Member Services*).

4) Contractor must ensure that Members are advised of their options for all contraceptive methods to allow them to provide informed consent for their choice of contraceptive method, including sterilization, as required by 22 CCR sections 51305.1 and 51305.3. Members of childbearing age may access the following services from an out-of-Network family planning Provider to temporarily or permanently prevent or delay pregnancy:

   a) Health education and counseling necessary to make informed choices and understand contraceptive methods;

   b) Limited history and physical examination;

   c) Laboratory tests if medically indicated as part of the decision-making process in choice of contraceptive methods, except pap smears if Contractor provides pap smears to meet the United States Preventive Services Taskforce (USPSTF) guidelines, http://www.uspreventiveservicestaskforce.org;

   d) Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning Provider;

   e) Provision of contraceptive pills, devices, and supplies;

   f) Tubal ligation;

   g) Vasectomies; and

   h) Pregnancy testing and counseling.

B. Sexually Transmitted Diseases

Contractor must ensure Members have access to Sexually Transmitted Disease (STD) services from any Network Provider or out-of-Network Provider without requiring Prior Authorization or referral. Contractor must allow Members to access out-of-Network STD services through Local Health Department (LHD) clinics, family planning clinics, or through other community STD service Providers.

C. HIV Testing and Counseling

Contractor must ensure that Members have access to confidential Human Immunodeficiency Virus (HIV) counseling and testing services from any Network Provider or out-of-Network Provider without requiring Prior Authorization.

D. Minor Consent Services

Contractor must ensure access to Minor Consent Services for Members **over the age of 12** ~~less than 18 years of age~~ from any Network Provider or out-of-Network Provider without requiring Prior Authorization. Contractor must ensure Members are informed of the availability of these services without Prior Authorization. Minors **over the age of 12** ~~less than 18 years of age~~ do not need parent, legal guardian, or Authorized Representative (AR) consent to access these services, and Contractor, Network Providers, Subcontractors, or Downstream Subcontractors are prohibited from disclosing any information relating to Minor Consent Services without the express consent of the minor Member. Minor Consent Services include treatment for the following:

1) Under Age 12

a) Pregnancy and pregnancy related services

b) Family planning services

c) Sexual assault services

2) Age 12 and Older ~~Under 21~~

a) Pregnancy and pregnancy related services

b) Family planning services

c) Sexual assault services

d) Infectious, contagious, or communicable disease diagnosis and treatment

e) Sexually transmitted diseases prevention (or infections), diagnosis, and treatment

f) Drug and alcohol abuse treatment and counseling

g) Outpatient mental health treatment and counseling. Minors may obtain outpatient mental health services, if in the opinion of the attending professional person determines that the minor is mature enough to participate intelligently in their health care pursuant to Family Code section 6924.

h) Intimate partner violence

~~1) Sexual assault, including rape;~~

~~2) Drug or alcohol abuse for Children ages 12 and over;~~

~~3) Pregnancy;~~

~~4) Family planning~~

~~5) STDs in Children ages 12 and over;~~

~~6) Diagnosis or treatment of infectious, contagious, or communicable diseases in minors 12 years of age or older if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer; and~~

~~7) NSMHS for Children ages 12 and.over outpatient mental health services who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924.~~

E. Immunizations

Members may access LHD clinics for immunizations regardless of whether the LHD is in the Network or out-of-Network, without Prior Authorization. Upon request, Contractor must provide updated information on the status of the Member's immunizations to the LHD clinic. Contractor must reimburse LHD clinics that provide immunizations to its Members after receipt of claims and supporting immunization records.

Back to Agenda Back to Item

F. Indian Health Care Providers

Contractor must ensure qualified Members have timely access to IHCPs within its Network, where available, as required by 42 USC section 1396j. IHCPs, whether in the Network or out-of-Network, can provide referrals directly to Network Providers without requiring a referral from a Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). Contractor must also allow for access to an out-of-Network IHCPs without requiring a referral from a Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b).

G. Certified Nurse Midwife and Nurse Practitioner Services

1) Contractor must ensure that its Members have access to CNM services as required by 42 United States Code (USC) section 1396d(a)(17) and 22 CCR section 51345.

2) Contractor must ensure its Members have access to Nurse Practitioner (NP) services as required in 22 CCR section 51345.1.

3) Contractor must inform its Members that they have a right to obtain out-of-Network CNM services if CNM services are not available in-Network.

H. Services to Which Network Provider, Subcontractor, or Downstream Subcontractor Has a Moral Objection

1) If a Network Provider, Subcontractor, or Downstream Subcontractor has religious or ethical objections to perform or otherwise support the provision of Covered Services, Contractor must timely arrange for, coordinate, and ensure the Member receives the Covered Services through referrals to a Provider that has no religious or ethical objection to performing the requested service or procedure, at no additional expense to DHCS or the Member.

2) Contractor's Member Handbook must identify services to which a Network Provider, Subcontractor, or Downstream Subcontractor may have a moral objection and explain that the Member has a right to obtain such services from another Provider. Contractor must also inform the Member that it will assist the Member in locating a Network Provider who will perform the service or procedure.

I. Federally Qualified Health Center, Rural Health Clinic, and Freestanding Birthing Center Services

Contractor must meet federal requirements for access to a FQHC, RHC, and FBC services consistent with 42 USC section 1396b(m) and Medicaid State Health Official Letter #16-006.

J. Community Based Adult Services

Contractor must provide Members with access to CBAS as set forth in the California Advancing and Innovating Medi-Cal (CalAIM) Special Terms and Conditions, or as set forth in any subsequent demonstration amendment or renewal, or successor demonstration, waiver, or other Medicaid authority. Without limitation, Contractor must do the following:

1) Provide and coordinate the provision of unbundled CBAS services for affected CBAS recipients as needed for continuity of care if there is a 5 percent reduction in CBAS Provider capacity in a county within the Service Area relative to the capacity that existed on April 1, 2012; and

2) Arrange Medically Necessary Covered Services for Members with similar clinical conditions as CBAS recipients if there is insufficient CBAS Provider capacity in a county in which ADHC was available prior to April 1, 2012, and coordinate their access to community resources to assist them to remain in the community.

5.2.9 Network and Access Changes to Covered Services

A. DHCS Notification Requirements

1) Contractor must provide notification to DHCS immediately upon discovery of a Network Provider initiated termination or at least 60 calendar days before any change occurs in the availability or location of services Contractor's Covered Services. Contractor must provide this notice if the change impacts more than 2,000 Members or impacts Contractor's ability to meet Network adequacy standards in accordance with APL 21-003. In the event of an emergency or other unforeseeable circumstance, Contractor must notify DHCS of the change in the availability or location of services as expeditiously as possible.

2) Contractor must provide notification to DHCS immediately, or within 10 calendar days of learning of a Provider's exclusionary status from any database or list included in APL 21-003.

3) Contractor must notify DHCS when it is unable to contract with a certified CBAS Provider or upon termination of a CBAS Network Provider Agreement. If Contractor and the CBAS Provider cannot come to an agreement on terms, Contractor must notify DHCS within five Working Days of Contractor's decision to exclude the CBAS Provider from its Network. DHCS may attempt to resolve the contracting issue when appropriate.

4) In accordance with APL 21-003, Contractor must notify DHCS within 60 calendar days of termination of a LTC Network Provider or immediately if the termination is a result of the LTC Network Provider having been decertified by the California Department of Public Health (CDPH). DHCS will attempt to resolve the contracting issue when appropriate. If termination of a LTC Network Provider Agreement is for a cause related to Quality of Care or patient safety concerns, Contactor may expedite termination of the LTC Network Provider Agreement and transfer Members to an appropriate, contracted LTC Provider in an expeditious manner. DHCS must be notified of the termination within 72 hours of said termination. Contractor must not continue to assign or refer Members to a LTC Network Provider during the 60 calendar days between notifying DHCS and the termination effective date.

B. Member Notification Requirements

1) Contractor must ensure Members are notified in writing of any changes in the availability or location of Covered Services, of any termination of a Network Provider, Subcontractor, or Downstream Subcontractor either 30 calendar days prior to the effective date of the contract termination or at least 15 calendar days after receipt of issuance of the termination notice, whichever is longer, unless directed by DHCS. The notification must be provided to each Member who received Primary Care from, or was seen on a regular basis by, the terminated Provider. This notification must also be submitted to DHCS in writing for approval before its release.

2) Contractor must obtain DHCS approval before sending a notice of termination to its Members no later than 60 calendar days prior to the effective date of the termination. Contractor may use a member notice template previously approved by DHCS. Any changes from

Back to Agenda Back to Item

the approved template must be submitted to DHCS 60 calendar days prior to the effective date of the termination for review and approval before mailing the notice. In the event of an emergency or other unforeseeable circumstance, Contractor must provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible.

5.2.10 Access Rights

A. Equal Access for Linguistic Services

Contractor must ensure equal access to the provision of high quality interpreter and linguistic services for LEP Members and Potential Members, and for Members and Potential Members with disabilities, in compliance with federal and State law, and APL 21-004.

B. Linguistic Services

1) Contractor must comply with W&I section 14029.91 and ensure that all monolingual, non-English-speaking, or LEP Members and Potential Members receive 24-hour interpreter services at all key points of contact, as defined in Paragraph B.4) of this provision, either through interpreters, telephone language services, or other legally compliant electronic options.

2) Contractor must ensure that any lack of interpreter services does not impede or delay a Member's timely access to care.

3) Contractor must comply with Title VI of the Civil Rights Act of 1964 and 42 CFR section 438.10(d) and have the capacity to provide, at minimum, the following linguistic services at no cost to Members or Potential Members:

a) Oral interpreters, sign language Providers, or bilingual Network Providers, Network Provider staff, Subcontractors, and Downstream Subcontractors at all key points of contact. These services must be provided in all languages spoken by Medi-Cal Members and Potential Members and not limited to those that speak the threshold or concentration standards languages.

b) Full and immediate translation of written materials pursuant to 42 CFR sections 438.10(d)(3), 438.404(a), and 438.408(d); W&I section 14029.91; and 22 CCR section

53876 for LEP Members and Potential Members who speak Threshold or Concentration Standard Languages, fully translated Member Information, including: the Member Handbook, Provider Directory, welcome packets, Marketing information, Member rights information, form letters and individual notices, including Notice of Action (NOA) letters, all notices related to Grievances and Appeals including Grievance and Appeal acknowledgement and resolution letters, and any other materials as required by Title VI of the Civil Rights Act of 1964 and APL 21-004;

c) Referrals to culturally and linguistically appropriate community service programs; and

d) Auxiliary Aids such as Telephone Typewriters (TTY)/ Telecommunication Devices for the Deaf (TDD), qualified interpreters including American Sign Language interpreters, and information in alternative formats including Braille, large print text (20 point font or larger), audio, and electronic formats, in accordance with written informing materials in alternative formats, selected by the Member, as specified in APL 21-004 and APL 22-002.

4) Key points of contact include:

a) Medical care settings, such as telephone, advice and Urgent Care transactions, and outpatient Encounters with Providers; and

b) Non-medical care settings, such as Member services, orientations, and appointment scheduling.

C. Access for Persons with Disabilities

Contractor must comply with the requirements of Titles II and III of the Americans with Disabilities Act of 1990 (42 USC sections 12131 et seq. and 12181 et seq.), section 1557 of the Affordable Care Act of 2010 (42 USC section 18116), sections 504 and 508 of the Rehabilitation Act of 1973 (29 USC sections 794 and 794d), Government Code (GC) sections 7405 and 11135, and all applicable implementing regulations, and must ensure access for people with disabilities including, without limitation, accessible web and electronic content, ramps, elevators, accessible restrooms, designated parking spaces, and accessible drinking water.

5.2.11 Cultural and Linguistic Programs and Committees

A. Cultural and Linguistic Program

1) Contractor must develop and implement policies and procedures for assessing the performance of its employees, contracted staff, and other individuals who provide linguistic services, addressing any identified gaps in the provision of cultural and linguistic services by Contractor's staff, and for overall monitoring and evaluation of its cultural and linguistic services programs.

2) Contractor must have in place and continually monitor, improve, and evaluate cultural and linguistic services that support the delivery of Covered Services to Members. Contractor must ensure it has proper policies and procedures in place to provide appropriate cultural and linguistic services for all of its Members.

3) Contractor must take immediate action to improve the delivery of culturally and linguistically appropriate services when deficiencies are noted.

4) Contractor must be active in recruiting and retaining culturally and linguistically competent Providers that reflect the needs of the Medi-Cal population in Contractor's Service Area.

5) Contractor must have a cultural and linguistic services program, as required by 22 CCR section 53876, that incorporates all requirements of applicable federal and State law, including without limitation those requirements cited in Exhibit A, Attachment III, Subsection 5.2.10 (*Access Rights*), 42 CFR section 438.206(c)(2), 22 CCR sections 51202.5 and 51309.5(a), and 28 CCR sections 1300.67.04(c)(2)(A) - (B) and 1300.67.04(c)(2)(G)(v) - (c)(4). Contractor must ensure immediate translation of all critical Member Information as required by 42 CFR sections 438.10, 438.404(a), and 438.408(d), and W&I section 14029.91.

6) Contractor must review and update its cultural and linguistic services programs to align with the Population Needs Assessment (PNA) implementation and subsequent findings. Contractor must ensure its Network Providers, Subcontractors, Downstream Subcontractors cultural and Health Equity linguistic services programs also align with the PNA.

7) Contractor must implement and maintain a written description of its cultural and linguistic services program which must include, at a minimum, the following:

   a) Its organizational commitment to deliver culturally and linguistically appropriate health care services;

   b) Services that comply with Title VI of the Civil Rights Act of 1964 (42 USC section 2000e et seq.), section 1557 of the Affordable Care Act of 2010 (42 USC section 18116), 42 CFR section 438.10, APL 21-004, and Exhibit A, Attachment III, Subsection 5.2.10 (*Access Rights*).

   c) Use of national standards for Culturally and Linguistically Appropriate Services (CLAS) for reference;

   d) An organizational chart showing the key staff with overall responsibility for cultural and linguistic services programs;

   e) A narrative explaining the organizational chart and describing the oversight and direction to the Community Advisory Committee (CAC), requirements for Contractor's support staff, and reporting relationships. Qualifications of Contractor's staff, including appropriate education, experience, and training must also be included;

   f) The role of the PNA to inform Contractor's cultural and linguistic services program priorities in compliance with Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*);

   g) The implementation and maintenance of annual sensitivity, diversity, communication skills, Health Equity, and cultural competency/humility training and related trainings (e.g., providing gender affirming care) for employees and contracted staff (clinical and non-clinical), as determined by Section C of this provision, Diversity, Equity, and Inclusion Training; and

   h) Contractor's administrative oversight and compliance monitoring of the cultural and linguistic services program and requirements for the delivery of culturally and linguistically appropriate health care services.

B. Linguistic Capability of Employees and Contracted Staff

Contractor must assess and track the linguistic capability of its interpreters or bilingual staff and contracted staff (clinical and non-clinical). Contractor must implement a system to provide adequate training regarding its language assistance programs to all employees and contracted staff who have routine contact with LEP Members or Potential Members and systematically address any identified gaps in Contractor's ability to address Members' cultural and linguistic needs. The training must include instruction on:

1) Contractor's policies and procedures for language assistance;

2) How to work effectively with LEP Members and Potential Members;

3) How to work effectively with interpreters in person and through video, telephone, and other media; and,

4) Understanding the cultural diversity of Members and Potential Members, and sensitivity to cultural differences relevant to delivery of health care interpretation services, in accordance with Exhibit A, Attachment III, Subsection 5.2.11 *(Cultural and Linguistic Programs and Committees).*

C. Diversity, Equity, and Inclusion Training

Contractor must provide annual sensitivity, diversity, cultural competency/humility and Health Equity training for its employees and contracted staff as detailed in APL 23-025. Training must consider structural and institutional racism and Health Inequities and their impact on Members, staff, Network Providers, Subcontractors, and Downstream Subcontractors. Contractor must ensure Network Providers and Allied Health Personnel receive pertinent information regarding the PNA findings and the identified targeted strategies. Contractor must use the most appropriate communication method(s) to assure the information can be accessed and understood. The training must include the following requirements:

1) Promote access and delivery of services in a culturally competent manner to all Members and Potential Members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender,

Back to Agenda Back to Item

gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56; and

2) Information about the Health Inequities and identified cultural groups in Contractor's Service Area which includes but is not limited to: the groups' beliefs about illness and health; need for gender affirming care; methods of interacting with Providers and the health care structure; traditional home remedies that may impact what the Provider recommends to treat the patient; and language and literacy needs.

D. Community Engagement

Contractor must develop a policy and procedure for a Member and family engagement strategy that involves Members and their families as partners in the delivery of Covered Services. This includes, but is not limited to the following:

1) Maintaining an organizational leadership commitment to engaging with Members and their families in the delivery of care;

2) Routinely engaging with Members and families through focus groups, listening sessions, surveys and/or interviews and incorporating results into policies and decision-making, as described in Exhibit A, Attachment III, Subsection 2.2.7.A (*Quality Improvement and Health Equity Annual Plan*);

3) Developing processes and accountability for incorporating Member and family input into policies and decision-making;

4) Developing processes to measures and/or monitor the impact of Member and family input into policies and decision-making;

5) Developing processes to share with Members and families how their input impacts policies and decision-making;

6) Conducting consumer surveys and incorporating results in Quality Improvement (QI) and Health Equity activities as described in Exhibit A, Attachment III, Subsection 2.2.9.C (*Consumer Satisfaction Survey*);

7) Partnering with community based organizations to cultivate Member and family engagement;

8) Maintaining a CAC whose composition reflects Contractor's Member population and whose input is actively utilized in policies and decision-making by Contractor, as outlined below in Exhibit A, Attachment III, Subsection 5.2.11.E. (*Cultural and Linguistic Programs and Committees*).

E. Community Advisory Committee (CAC)

1) Contractor must have a diverse CAC pursuant to 22 CCR section 53876(c), comprised primarily of Contractor's Members, as part of Contractor's implementation and maintenance of Member and community engagement with stakeholders, community advocates, traditional and Safety-Net Providers, and Members.

2) CAC Membership

a) Contractor must convene a CAC selection committee tasked with selecting the members of the CAC. Contractor must demonstrate a good faith effort to ensure that the CAC selection committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the CAC:

i. Persons who sit on Contractor's Governing Board, which should include representation in the following areas: Safety Net Providers including FQHCs, Behavioral Health Providers, Regional Centers (RC), Local Education Agencies (LEAs), dental Providers, IHCPs, and Home and Community-Based Service (HCBS) program Providers; and

ii. Persons and community-based organizations who are representatives of each county within Contractor's Service Area adjusting for changes in membership diversity.

b) The CAC selection committee must ensure the CAC membership reflects the general Medi-Cal Member population in Contractor's Service Area, including representatives from IHCPs, and adolescents and/or parents and/or caregivers of Children, including foster youth, as appropriate and be modified as the population changes to ensure that Contractor's community is represented and engaged. The CAC selection committee must make good

Back to Agenda Back to Item

faith efforts to include representatives from diverse and hard-to-reach populations on the CAC, with a specific emphasis on persons who are representative of or serving populations that experience Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.

c) Contractor's CAC selection committee must select all of its CAC members promptly no later than 180 calendar days from the effective date of this contract.

d) Should a CAC member resign, is asked to resign, or is otherwise unable to serve on the CAC, Contractor must make its best effort to promptly replace the vacant seat within 60 calendar days of the CAC vacancy.

e) Contractor must designate a CAC coordinator and maintain a written job description detailing the CAC coordinator's responsibilities, which must include having responsibility for managing the operations of the CAC in compliance with all statutory, rule, and contract requirements, including, but not limited to:

i. Ensuring CAC meetings are scheduled and committee agendas are developed with the input of CAC members;

ii. Maintaining CAC membership, including outreach, recruitment, and onboarding of new members, that is adequate to carry out the duties of the CAC;

iii. Actively facilitating communications and connections between the CAC and Contractor leadership, including ensuring CAC members are informed of Contractor decisions relevant to the work of the CAC;

iv. Ensuring that CAC meetings, including necessary facilities, materials, and other components, are accessible to all participants and that appropriate accommodations are provided to allow all attending the meeting, including, but not limited to, accessibility for individuals with a disability or LEP Members to effectively communicate and participate in CAC meetings;

v. Ensuring compliance with all CAC reporting and public posting requirements; and

vi. The CAC coordinator may be an employee of Contractor, Subcontractor, or Downstream Subcontractor. Contractor's CAC coordinator must not be a member of the CAC or a Member enrolled with Contractor.

3) CAC Meetings

a) Contractor must hold its first regular CAC meeting promptly after all initial CAC members have been selected by the CAC selection committee and at least quarterly thereafter.

b) Contractor must make the regularly scheduled CAC meetings open to the public, posting meeting information publicly on Contractor's website in a centralized location 30 calendar days prior to the meeting, and in no event later than 72 hours prior to the meeting.

c) Contractor must provide a location for CAC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants and providing accommodations to allow all individuals to attend and participate in the meetings.

d) CAC must draft written minutes of each of its meetings and the associated discussions. All minutes must be posted on Contractor's website and submitted to DHCS no later than 45 calendar days after each meeting. Contractor must retain the minutes for no less than ten years and provided to DHCS, upon request.

e) Contractor must ensure that CAC members are supported in their roles on the CAC, including but not limited to providing resources to educate CAC members to ensure they are able to effectively participate in CAC meetings, providing transportation to CAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest CAC member participation possible.

Back to Agenda Back to Item

f) Contractor must demonstrate that CAC input is considered in annual reviews and updates to relevant policies and procedures, including CAC input pursuant to Exhibit A, Attachment III, Subsection 5.2.11.E. (*Cultural and Linguistic Programs and Committees)* that is relevant to policies and procedures affecting quality and Health Equity. Contractor must provide a feedback loop to inform CAC members how their input has been incorporated.

4) Duties of the CAC

The CAC must carry out the duties as set forth in this Contract. Such duties include, but are not limited to:

a) Identifying and advocating for Preventive Care practices to be utilized by Contractor;

b) Contractor must ensure that the CAC is included and involved in developing and updating cultural and linguistic policy and procedure decisions including those related to QI, education, and operational and cultural competency issues affecting groups who speak a primary language other than English. The CAC may also advise on necessary Member or Provider targeted services, programs, and trainings;

c) The CAC must provide and make recommendations to Contractor regarding the cultural appropriateness of communications, partnerships, and services;

d) Contractor must engage their CAC as a part of their participation in LHJs' CHA/CHIP process, as defined further in the PHM Policy Guide;

e) Contractor must provide sufficient resources for the CAC to support the required CAC activities outlined above, including supporting the CAC in engagement strategies such as consumer listening sessions, focus groups, and/or surveys; and

f) The CAC must provide input and advice, including, but not limited to, the following:

i. Culturally appropriate service or program design;

ii. Priorities for health education and outreach program;

iii. Member satisfaction survey results;

iv. Findings of the PNA;

v. Plan Marketing Materials and campaigns.

vi. Communication of needs for Network development and assessment;

vii. Community resources and information;

viii. Population Health Management;

ix. Quality;

x. Health Delivery Systems Reforms to improve health outcomes;

xi. Carved Out Services;

xii. Coordination of Care; and

xiii. Health Equity;

xiv. Accessibility of Services

5) Contractor's Annual CAC Demographic Report

To ensure Contractor's CAC membership is representative of the Communities in Contractor's Service Area, Contractor must complete and submit to DHCS annually an Annual CAC Member Demographic Report by April 1 of each year. The Annual CAC Member Demographic Report must include descriptions of all of the following:

a) The demographic composition of CAC membership;

b) How Contractor defines the demographics and diversity of its Members and Potential Members within Contractor's Service Area;

Back to Agenda Back to Item

c) The data sources relied upon by Contractor to validate that its CAC membership aligns with Contractor's Member demographics;

d) Barriers to and challenges in meeting or increasing alignment between CAC's membership with the demographics of the Members within Contractor's Service Area;

e) Ongoing, updated and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the Members within Contractor's Service Area; and

f) A description of the CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped Contractor initiatives and/or policies.

5.2.12 Continuity of Care for Seniors and Persons with Disabilities

A. For newly enrolled Seniors and Persons with Disabilities (SPD) who request continuity of care, Contractor must provide continued access for up to 12 months to an out-of-Network Provider with whom the SPD Member has an ongoing relationship, as long as Contractor has no Quality of Care issues with the Provider and the Provider will accept either Contractor's or the Medi-Cal FFS Rates, whichever is higher, pursuant to W&I section 14182(b)(13) - (14). Contractor must use Medi-Cal FFS utilization data from DHCS to confirm that the SPD Member has an ongoing relationship with the Provider.

B. Contractor must allow all Members to request continuity of care in accordance with 42 CFR section 438.62 and APL 23-022.

C. Contractor must provide for the completion of Covered Services at the request of a Member in accordance with H&S section 1373.96. All Members with pre-existing Provider relationships who make a continuity of care request must be given the option to continue treatment for up to 12 months with an out-of-Network Provider, if the following criteria are met:

1) The Member has seen the out-of-Network Provider at least once within the 12 months before Enrollment with Contractor;

2) The out-of-Network Provider accepts Contractor's rate offered in accordance with H&S section 1373.96(d)(2) or (e)(2); and

3) The out-of-Network Provider meets Contractor's applicable professional standards and has no disqualifying Quality of Care issues.

D. Contractor must conduct Person-Centered Planning for SPD Members as follows:

1) Upon the Enrollment of a SPD Member, Contractor must provide, or ensure the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD Member's continuing health care needs.

2) Contractor must include identifying each SPD Member's preferences and choices regarding treatments and services, and abilities.

3) Contractor must allow or ensure the participation of the SPD Member, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.

4) Contractor must ensure that SPD Members receive all necessary information regarding treatment and services so that they may make an informed choice.

5) Complex Case Management services for SPD Members must include the concepts of Person-Centered Planning.

E. Contractor must ensure the provision of Discharge Planning when a SPD Member is admitted to a hospital or institution and continuation into the post-discharge period. Discharge Planning must include ensuring that necessary care, services, and supports are in place in the community for the SPD Member once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the SPD Member and/or caregiver. The minimum criteria for a Discharge Planning checklist must include:

1) Documentation of pre-admission status, including living arrangements, physical and mental function, social support, Durable Medical Equipment (DME), and other services received.

2) Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD Member or an AR of the SPD Member as applicable, physical and mental function, financial resources, and social supports.

3) Services needed after discharge, the type of placement preferred by the SPD Member or their AR and hospital/institution, type of placement agreed to by the SPD Member or their AR, the specific agency or home recommended by the hospital, the specific agency or home agreed to by the SPD Member or their AR, and the pre-discharge counseling that is recommended.

4) Summary of the nature and outcome of the SPD Member's, or their AR's, involvement in the Discharge Planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital or institution.

5.2.13 Network Reports

A. Network Certification Report

1) Contractor must submit its Network certification report to DHCS. The report must demonstrate Contractor's capacity to serve the current and expected membership for its Service Area in accordance with 42 CFR section 438.207(b), W&I section 14197(f)(1), and APL 23-001.

2) Contractor must demonstrate good faith compliance with contracting and referral requirements with certain cancer centers in accordance with W&I section 14197.45.

3) Contractor must demonstrate how it will arrange for Covered Services to Members through the use of NEMT, NMT, and Telehealth if Contractor does not meet time or distance standards for adult and pediatric PCPs, core Specialist and outpatient mental health Providers in accordance with W&I section 14197(f)(2).

4) Contractor must submit Network certification in accordance with the requirements placed upon DHCS pursuant to 42 CFR section 438.66(e). Contractor must submit its Network certification report as

Back to Agenda Back to Item

outlined in APL 23-001. As part of the Network certification report, Contractor must provide documentation demonstrating efforts to recruit new Providers to areas that do not meet time or distance standards without the use of an AAS request.

B. Periodic Reporting Requirements

1) Contractor must report to DHCS any time there is a Significant Change to Contractor's Network that affects Network capacity and Contractor's ability to provide health care services, such as the following:

a) Change in Covered Services or benefits;

b) Change in geographic Service Area;

c) Change in the composition of, or the payments to, its Network Providers, Subcontractors, or Downstream Subcontractors; or

d) Enrollment of a new population.

2) Contractor must provide supporting documentation detailing any Significant Change to DHCS. DHCS will determine what information Contractor must provide after Contractor reports a Significant Change to its Network pursuant to 42 CFR section 438.207.

C. Network Change Report

1) Contractor must submit to DHCS, in a format specified by DHCS, a report summarizing changes in the Network.

2) Contractor must submit the report 30 calendar days following the end of the reporting quarter.

D. Subcontractor and Downstream Subcontractor Network Certification Report

1) Contractor must develop, implement, and maintain a process to annually certify the Network(s) of its Subcontractor(s) and Downstream Subcontractor(s) that provide Medi-Cal Covered Services for compliance with Network Ratios set forth in Exhibit A, Attachment III, Subsection 5.2.4 (*Network Ratios*), Network

Adequacy Standards set forth in Subsection 5.2.5 (*Network Adequacy Standards*), and Network Composition requirements set forth in Exhibit A, Attachment III, Subsection 5.2.3 (*Network Composition*) of this Contract in accordance with APL 23-006.

2) Contractor must submit complete and accurate Network Provider Subcontractor and Downstream Subcontractor Network Provider Data to confirm its Subcontractor Network(s) is compliant with all applicable network adequacy requirements, as set forth in Exhibit A, Attachment III, Subsection 2.1.4 (*Network Provider Data Reporting*).

3) Contactor must have a process in place to impose Corrective Action and sanctions and report to DHCS when Subcontractor and Downstream Subcontractors that provide Covered Services fail to meet Network adequacy standards as set forth in APL 23-006. Contractor must ensure all Members assigned to a Subcontractor or Downstream Subcontractor Network that is under a Corrective Action continue access to Medically Necessary Covered Services within timely access standards and applicable time or distance standards as set forth in Exhibit A, Attachment III, Subsection 5.2.5 (*Network Adequacy Standards*) by supplementing the Subcontractor or Downstream Subcontractor Network until the Corrective Action is resolved.

4) Contractor must submit Network certification in accordance with the requirements placed upon DHCS pursuant to 42 CFR section 438.66(e). Contractor must submit the results of its Subcontractor and Downstream Subcontractor Network Certification to DHCS in a format specified by DHCS and post its submitted certification on its website.

5.2.14 Site Review

A. General Requirement

1) Contractor must conduct Facility Site Reviews (FSR) and Medical Record reviews, initially and every three years, on all PCP sites in accordance with APL 22-017. Contractor must ensure that Network Providers, Subcontractors, and Downstream Subcontractors have the capacity to provide Primary Care services, appropriate Preventive Care services, coordination and continuity of care in accordance with 42 CFR section 438.207.

Back to Agenda Back to Item

2) Contractor must ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities. Contractor must also conduct facility site physical accessibility reviews on PCP sites, Provider sites which serve a high volume of SPD Members, and all Provider sites including CBAS and ancillary service Providers, in accordance with Policy Letter (PL) 12-006 and W&I section 14182(b)(9).

B. Pre-Operational Site Reviews

The number of Site Reviews to be completed prior to initiating Contractor operation in a Service Area must be based upon the total number of new Primary Care sites in the Network. For more than 30 sites in the Network, a five (5) percent sample size or a minimum of 30 sites, whichever is greater in number, must be reviewed six (6) weeks prior to Contractor operation. Site Reviews must be completed on all remaining sites within six (6) months of Contractor operation. For 30 or fewer sites, reviews must be completed on all sites six (6) weeks prior to Contractor operation.

C. Credentialing Site Review

A Site Review is required as part of the Credentialing process when both the facility and the Provider are added to Contractor's Network. If a Provider is added to Contractor's Network, and the Provider site has a current passing Site Review survey score, a site survey need not be repeated for Provider Credentialing or recredentialing purposes.

D. Corrective Action

Contractor must ensure that a Corrective Action plan is developed to correct cited deficiencies and that corrections are completed and verified within the established guidelines as specified in APL 22-017. PCP sites that do not correct cited deficiencies must be terminated from Contractor's Network; Contractor must assign Members to other Network Providers in accordance with APL 21-003.

E. Data Submission

Contractor must submit the Site Review data to DHCS up to quarterly, or in a manner or timeframe specified by DHCS. All data elements defined by DHCS must be included in the data submission report.

F. Continuing Oversight

Contractor must retain accountability for all Site Review activities even if this function is delegated.

G. Medical Record Documentation

1) General Requirement

Contractor must ensure the documentation of appropriate Medical Records for Members and that Medical Records are available to Providers at each Encounter in accordance with 42 USC section 1396a(w), 28 CCR section 1300.67.1(c), and APL 20-006.

2) Medical Records

Contractor must have policies and procedures for developing, implementing and maintaining written procedures for all forms of Medical Record retention including but not limited to:

a) For storage and filing of Medical Records including: collection, processing, maintenance, storage, retrieval, identification, and distribution;

b) To ensure that Medical Records are protected and confidential in accordance with all federal and State law;

c) For the release of information and obtaining consent for treatment; and

d) To ensure maintenance of Medical Records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

3) On-Site Medical Records

Contractor must have policies and procedures to ensure that an individual is delegated the responsibility for securing and maintaining the security of Medical Records at each site.

4) Member Medical Record

Contractor must ensure that a complete, legible Medical Record is maintained for each Member in accordance with 22 CCR section

53861, which reflects all aspects of patient care, including, but not limited to, ancillary services, and at a minimum includes:

a) Member identification on each page; personal/biographical data in the record;

b) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services in accordance with Title VI of the Civil Rights Act of 1964;

c) All entries dated with the author identified. For Member visits, all entries must include at a minimum, the documentation of subjective complaints, the objective findings, the plan for diagnosis and treatment, and follow-up care;

d) A problem list, a complete record of immunizations and health maintenance or preventive services rendered, and documentation of any outreach efforts surrounding any missed appointments;

e) Allergies and adverse reactions prominently noted;

f) All appropriate informed consent documentation, including the human sterilization consent procedures required by 22 CCR sections 51305.1 - 51305.6, if applicable;

g) Reports of Emergency Services provided (directly by the Network Provider or through an emergency room) and the hospital discharge summaries for all hospital admissions, including any follow-up after the provision of Emergency Services or hospitalizations;

h) Consultations and referrals, including for Complex Care Management (CCM), Enhanced Care Management, and Specialists, as well as evidence of review of specialty referrals, pathology, and laboratory reports. Any abnormal results must have an explicit notation in the Medical Record, including follow-up or outreach;

i) For Medical Records of adults, documentation of whether the individual has been informed and has executed an

Advance Directive, such as a durable power of attorney, for health care for Members ages 18 and over;

j) Health education behavioral assessment and referrals to health education services where appropriate; and

k) Documentation of blood lead screening, immunizations, and other preventive services provided in accordance with the American Academy of Pediatrics Bright Futures Periodicity Schedule, the United States Preventive Services Task Force Grade A and B recommendations, the American College of Obstetrics and Gynecologists, and the Advisory Committee on Immunization Practice recommendations. Member refusal to receive blood lead screening, immunizations, or other preventive services must also be documented in the Member's Medical Record as described in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*).

5.2.15 Street Medicine

Contractor may provide medical and other Covered Services as described in APL 24-001 via a Street Medicine program for Members experiencing unsheltered homelessness through contracted Street Medicine Providers. Street Medicine Providers are Providers or entities that Contractor has determined can provide Street Medicine services to eligible Members in an effective manner consistent with Street Medicine industry protocols and practices. Street Medicine Providers may act in the role of the Member's assigned PCP, through a direct contract with Contractor, as an Enhanced Care Management (ECM) Provider, a Community Supports Provider, a referring or treating contracted Provider, or Community Health Worker as set forth in APL 24-001. This subsection refers only to Street Medicine programs and Street Medicine Providers that Contractor may choose to offer.

A. Contracted Street Medicine Providers acting in the role of a Member's assigned PCP are licensed physician and non-physician medical practitioners (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), NP, and CNM. For a non-physician medical practitioner (PA, NP, and CNM), Contractors must ensure compliance with State law and Contract requirements regarding physician supervision of non-physician medical practitioners. Additionally, given the unique and specialized nature of Street Medicine, a supervising Physician must be a practicing Street Medicine provider, with knowledge of, and experience in, Street Medicine clinical guidelines and protocols. Street Medicine Providers who choose to act as a Member's assigned

PCP must agree to provide the essential components of the Medical Home in order to provide comprehensive and continuous medical care, such as Basic Population Health Management; Care Coordination and health promotion; support for Members, their families, and their ARs; referrals to Specialists, including Behavioral Health, community, and social support services, when needed; use of Health Information Technology to link services, as feasible and appropriate; and provision of primary and preventative services to assigned Members. If the Street Medicine Provider does not have the capability to provide Primary Care services on the street, the Street Medicine Provider must be affiliated with a facility that has a physical location.

B. Contractor must ensure Street Medicine Providers have the capability to, and comply with, referral and Care Coordination, administrative, billing and claim, data sharing, and reporting requirements.

C. Contractor must ensure Street Medicine Providers acting in the capacity of an ECM and/or Community Supports Providers comply with requirements as set forth in APL 21-012 and/or APL 21-017. Contractor is to ensure Street Medicine Providers receive appropriate Provider training and manuals and have adequate systems in place to adhere to such requirements.

D. Contractor must submit contractually required policies and procedures exhibiting compliance with program policy and requirements, and receive approval from DHCS, before operating a Street Medicine program.

Exhibit A, ATTACHMENT III

5.3 Scope of Services

5.3.1 Covered Services
5.3.2 Medically Necessary Services
5.3.3 Initial Health Appointment
5.3.4 Services for Members Less Than 21 Years of Age
5.3.5 Services for Adults
5.3.6 Pregnant and Postpartum Members
5.3.7 Services for All Members
5.3.8 Investigational Services

5.3 Scope of Services

5.3.1 Covered Services

A. Contractor must provide or arrange for all Covered Services for Members, in accordance with the definition of Covered Services set forth in Exhibit A, Attachment I, Article 1.0 (*Definitions*). Contractor must ensure that Covered Services and other services required in this Contract are provided to a Member in an amount no less than what is offered to Medi-Cal beneficiaries in Medi-Cal Fee-For-Service (FFS), as defined in the most current Medi-Cal Provider Manual and consistent with current, evidence-based medical standards. Contractor has the primary responsibility to provide all Covered Services, including services that exceed the services provided by Local Education Agencies (LEAs), Regional Centers (RCs), or local governmental health programs.

B. Contractor must ensure that services provided are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the Covered Services are furnished. Contractor must not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of the diagnosis, type of illness, or condition. Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity or utilization control for services that are not medical services (such as Community Support services), provided the services furnished are reasonably expected to achieve their purpose and are provided in a manner that reflects the Member's ongoing needs, including but not limited to services for chronic conditions.

C. Except as set forth in Attachment 3.1.B.1 of the California Medicaid State Plan or as otherwise authorized by Welfare and Institutions Code (W&I) section 14133.23, drug benefits for Members who are eligible for drug benefits under 42 United States Code (USC) section 1395w-101 *et seq*.) are not a Covered Service under this Contract. Contractor must comply with all applicable provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003, Policy Letter (PL) 108–173, December 8, 2003, 117 Stat 2066.

D. Unless expressly excluded under this Contract, Contractor must cover any services necessary for compliance with the requirements for parity in mental health and Substance Use Disorder (SUD) benefits, and ensure that Members are given access to all mental health and SUD services in accordance with 42 Code of Federal Regulations (CFR) section 438.900. The types, amount, duration, and scope of these services must be

consistent with the parity compliance analysis conducted by either DHCS or Contractor.

1) If Contractor provides Members with mental health or SUD services in any classification of benefits as described in 42 CFR section 438.910(b)(2), then Contractor must provide to Members those services in every classification that is listed therein and is covered by Contractor. In determining the classification in which a particular benefit belongs, Contractor must apply the same reasonable standards for medical/surgical benefits to mental health or SUD benefits.

2) Contractor must provide referrals and Care Coordination for all non-covered mental health and SUD services, as required in Exhibit A, Attachment III, Subsections 4.3.12 (*Mental Health Services*) and 4.3.13 (*Alcohol and Substance Use Disorder Treatment Services*).

E. Covered Services may be provided to Members through Telehealth, as defined in W&I section 14132.72, and as follows:

1) Contractor is responsible for ensuring that Covered Services provided via a Telehealth modality meet DHCS guidelines in outlined in the Provider Manual.

2) Contractor must oversee that Providers only provide Covered Services that can be appropriately delivered via Telehealth, and that they not provide Covered Services that would otherwise require the in-person presence of the Member for any reason, such as those that are performed in an operating room or while the Member is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices.

3) Contractor must ensure all Providers furnishing applicable Covered Services via audio-only synchronous interactions also offer those same services via video synchronous interactions.

4) Contractor must ensure all Providers furnishing services through video synchronous interactions or audio-only synchronous interactions must do one of the following:

a) Offer those same services via in-person, face-to-face contact.

b) Arrange for a referral to, and a facilitation of, in-person care that does not require a Member to independently contact a different Provider to arrange for that care.

5) Contractor is responsible for ensuring Members are informed prior to the initial delivery of Covered Services via Telehealth about the use of Telehealth. Contractor must also ensure Providers obtain and document verbal or written consent from Members for the use of Telehealth as an acceptable mode of delivering services prior to the initial delivery of Covered Services. Consent must be documented in the Member's Medical Record and made available to DHCS upon request.

6) Contractor must communicate to Providers any periodical updates to Covered Services and Provider types and requirements that may be appropriately delivered through Telehealth.

5.3.2 Medically Necessary Services

Contractor must apply the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity for Members less than 21 years of age, as set forth in 42 USC section 1396d(r)(5) and All Plan Letter (APL) 23-005. The terms Medically Necessary, or Medical Necessity, are defined in Exhibit A, Attachment I, Article 1.0 (*Definitions*), based upon whether a Member is less than 21 years of age, or ages 21 and over.

5.3.3 Initial Health Appointment

Contractor must ensure provision of an Initial Health Appointment (IHA) in accordance with 22 California Code of Regulations (CCR) sections 53851(b)(1), 53910.5(a)(1) and APL 22-030. An IHA at a minimum must include: a history of the Member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, a physical examination, and the diagnosis and plan for treatment of any diseases, unless the Member's Primary Care Provider (PCP) determines that the Member's Medical Record contains complete information, updated within the previous 12 months, consistent with the assessment requirements. Contractor must continue to hold Network Providers accountable for providing all preventive screenings for adults and Children as recommended by the United States Preventive Services Taskforce (USPSTF) but will no longer require all of these elements to be completed during the IHA, so long as Members receive all required screenings in a timely manner consistent with USPSTF guidelines.

A. Contractor must cover and ensure the provision of an IHA for each new Member within timelines stipulated in Exhibit A, Attachment III, Subsections 5.3.4 (*Services for Members Less Than 21 Years of Age*) and 5.3.5 (*Services for Adults*) below.

B. Contractor must ensure that a Member's completed IHA is documented in their Medical Record and that appropriate assessments from the IHA are available during subsequent health visits.

C. Contractor must make reasonable attempts to contact a Member to schedule an IHA. Contractor must document all attempts to contact a Member. Documented attempts that demonstrate Contractor's efforts to unsuccessfully contact a Member and schedule an IHA will be considered evidence in meeting this requirement. Contractor may delegate these activities, but Contractor remains ultimately responsible for all delegated functions, as outlined in Exhibit A, Attachment III, Subsection 3.1.1 (*Overview of Contractor's Duties and Obligations*).

5.3.4 Services for Members Less Than 21 Years of Age

Contractor must cover and ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members less than 21 years of age required under the EPSDT benefit described in 42 USC section 1396d(r), W&I section 14132(v), and APL 23-005. The EPSDT benefit includes all Medically Necessary health care, diagnostic services, treatments, and other services listed in 42 USC section 1396d(a), whether or not covered under the California Medicaid State Plan. All EPSDT services are Covered Services unless expressly excluded under this Contract.

A. Provision of IHA for Members Less Than 21 Years of Age

1) For Members less than 18 months of age, Contractor must ensure the provision of an IHA within 120 calendar days following the date of Enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures for ages two and younger, whichever is sooner.

2) For Members ages 18 months and older, Contractor must ensure an IHA is performed within 120 calendar days of Enrollment.

3) The IHA must provide, or arrange for provision of, all immunizations necessary to ensure that the Member is up to date for their age, Adverse Childhood Experiences (ACEs) screening, and any

required age-specific screenings including developmental screenings.

4) If the provisions of the IHA are not met, then Contractor must ensure case management and Care Coordination are working directly with the Member to receive appropriate services to include but not limited to health screenings, immunizations, and risk assessments.

B. Children's Preventive Services

1) Contractor must provide preventive health visits for all Members less than 21 years of age at times specified by the most recent AAP Bright Futures Periodicity Schedule and anticipatory guidance as outlined in the AAP Bright Futures Periodicity Schedule. Contractor must provide, as part of the periodic preventive visit, all age-specific assessments and services required by AAP Bright Futures.

2) Where a request is made for Children's preventive services by the Member, the Member's parent, legal guardian, or Authorized Representatives (ARs), or through a referral, an appointment must be made for the Member to have a visit within ten Working Days of the request, unless Member declines a visit within ten Working Days of the request and another appointment date is chosen by the Member.

3) At each Non-emergency Primary Care visit with a Member less than 21 years of age, the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, must be advised of the Children's preventive services due and available from Contractor. Documentation must be entered in the Member's Medical Record which indicates the receipt of Children's preventive services in accordance with the AAP Bright Futures standards. If the services are refused, documentation must be entered in the Member's Medical Record which indicates the services were advised, and the Member's (if an emancipated minor), or the parent, legal guardian, or AR of the Member's voluntary refusal of these services.

4) All children's preventive services, including all confidential screening and billing reports for EPSDT screening, treatment, and Care Coordination, must be reported as part of the Encounter Data submittal required in Exhibit A, Attachment III, Subsection 2.1.2

(*Encounter Data Reporting*). Contractor must ensure appropriate acquisition for missed reporting of Children's preventive services.

C. Immunizations

1) Contractor must cover vaccinations, except for vaccinations expressly excluded in DHCS guidance to Medi-Cal Managed Care Health Plans, at the time of any health care visit and ensure the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by Advisory Committee on Immunization Practices (ACIP). Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the vaccination will be considered sufficient in meeting this requirement. When practical, reasons for failed attempts should be medically coded.

2) At each Non-Emergency Primary Care visit with Members less than 21 years of age, the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, must be advised of the vaccinations due and available from Contractor immediately, if the Member has not received vaccinations in accordance with ACIP standards. Documentation must be entered in the Member's Medical Record which indicates the receipt of vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation must be entered in the Member's Medical Record which indicates the vaccinations were advised, and the Member's (if an emancipated minor), or the parent, legal guardian, or AR of the Member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is required that the Medical Record must demonstrate that the Member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations.

3) Contractor must ensure that Member-specific vaccination information is reported to immunization registries established in Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports must be made following the Member's IHA and all other health care visits that result in an administered vaccine within 14 calendar days. Reporting must be in accordance with all applicable State and federal laws.

4) Within 30 calendar days of Federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization

Back to Agenda Back to Item

purposes, Contractor must develop policies and procedures for the provision and administration of the vaccine. Contractor must cover and ensure the provision of the vaccine from the date of its approval regardless of whether or not the vaccine has been incorporated into the Vaccines for Children (VFC) Program. Policies and procedures must be in accordance with Medi-Cal guidelines issued prior to final ACIP recommendations.

5) Contractor must provide information to all Network Providers regarding the VFC Program and is encouraged to promote and support Enrollment of applicable Network Providers in the VFC program as see appropriate.

D. Screening for Childhood Lead Poisoning

1) Contractor must cover and ensure the provision of blood lead screening tests to Members at the ages and intervals specified in 17 CCR sections 37000 - 37100, and in accordance with APL 20-016. Contractor must ensure its Network Providers follow the Childhood Lead Poisoning Prevention Branch (CLPPB) guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including, without limitation, appropriate referrals to the local public health department.

a) While requirements for appropriate follow-up activities, including referral, case management, and reporting, are set forth in the CLPPB guidelines, a Network Provider may determine that additional services that fall within the EPSDT benefit are Medically Necessary.

b) Contractor must ensure that Members less than 21 years of age receive all Medically Necessary care as required under EPSDT.

2) Contractor must identify, at least quarterly, all Members less than six years of age with no record of receiving a required blood lead screening test. Contractor must identify the age(s) at which a required blood lead screening test was missed, including Members under the age of six, without any record of a completed blood lead screening test at each age. On a quarterly basis, Contractor must notify the Network Provider responsible for the care of an identified Member of the requirement to test the Member and provide the written or oral anticipatory guidance as required pursuant to 17 CCR section 37100. For a period of no less than ten years,

Back to Agenda Back to Item

Contractor must maintain records of all Members identified quarterly as having no documentation of receiving a required blood lead screening test, and provide those records to DHCS at least annually, as well as upon request.

3) If the Member, or the Member's parent, legal guardian, or AR, refuses the blood lead screening test, Contractor must ensure a signed statement of voluntary refusal by the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, is documented in the Member's Medical Record.

4) If Contractor is unable to ensure a signed statement of voluntary refusal is documented in the Member's Medical Record because the Member, or the Member's parent, legal guardian, or AR refuses or declines to sign, or is unable to sign, such as when services are provided through a Telehealth modality, Contractor must ensure that the reason for not obtaining a signed statement of voluntary refusal is documented in the Member's Medical Record.

5) DHCS will consider unsuccessful attempts to provide the required blood lead screening tests that are documented in the Member's Medical Record in accordance with the requirements in Exhibit A, Attachment III, Subsection 5.3.4.D. (*Services for Members Less Than 21 Years of Age*) as evidence of Contractor's compliance with blood lead screening test requirements.

E. EPSDT Services

1) For Members less than 21 years of age, Contractor must comply with all requirements identified in APL 23-005. Contractor must provide, or arrange and pay for, all Medically Necessary EPSDT services, including all Medicaid services listed in 42 USC section 1396d(a), whether or not included in the California Medicaid State Plan, unless expressly excluded in this Contract. Covered Services will include, without limitation, in-home nursing provided by home health agencies or individual nurse Providers, as required by APL 20-012, Care Coordination, case management, and Targeted Case Management (TCM) services. If Members less than 21 years of age are not eligible or accepted for Medically Necessary TCM services by a RC or local government health program, per requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*), Contractor must arrange for comparable services for the Member under the EPSDT benefit in accordance with APL 23-005.

2) Contractor must arrange for any Medically Necessary diagnostic and treatment services identified at a preventive screening or other visit indicating the need for diagnosis or treatment, either directly or through referral to appropriate agencies, organizations, or individuals, as required by 42 USC section 1396a(a)(43)(C), APL 23-005, and APL 20-012. Contractor must ensure that all Medically Necessary EPSDT services, including all Covered Services set forth in Exhibit A, Attachment III, Subsection 5.3.4.E.1) (*Services for Members Less Than 21 Years of Age*), above, as well as EPSDT services carved out of this Contract, are provided in a timely manner, as soon as possible but no later than 60 calendar days following the preventive screening or other visit identifying a need for diagnosis or treatment. Without limitation, Contractor must identify available Providers, including if necessary out-of-Network Providers and individuals eligible to enroll as Medi-Cal Providers, to ensure the timely provision of Medically Necessary EPSDT services. Contractor must provide appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), to and from medical appointments for Covered Services and pharmacy services. NMT must also be provided for services not covered under this Contract.

3) Covered Services do not include California Children's Services (CCS), pursuant to Exhibit A, Attachment III, Subsection 4.3.14 (*California Children's Services*), or Specialty Mental Health Services (SMHS), pursuant to Exhibit A, Attachment III, Subsection 4.3.12 (*Mental Health Services*). Contractor must ensure that the case management for Medically Necessary services authorized by CCS, county mental health plans, Drug Medi-Cal or Drug Medi-Cal Organized Delivery System (DMC-ODS)Plans under this Subsection is equivalent to that provided by Contractor for Covered Services for Members less than 21 years of age under this Contract and must, if indicated or upon the Member's request, provide additional Care Coordination and case management services as necessary to meet the Member's medical and Behavioral Health needs.

F. Behavioral Health Treatment Services

For Members less than 21 years of age, Contractor must cover Medically Necessary Behavioral Health Treatment (BHT) services regardless of diagnosis in compliance with APL 22-006 and APL 23-010.

1) Contractor must provide Medically Necessary BHT services in accordance with a recommendation from a licensed physician, surgeon, or a licensed psychologist and must provide continuation of BHT services under continuity of care.

2) The Member's treatment plan must be reviewed, revised, and/or modified no less than every six months by a BHT service Provider. The Member's behavioral treatment plan may be modified or discontinued only if it is determined that the services are no longer Medically Necessary under the EPSDT Medical Necessity standard.

3) Contractor has primary responsibility for the provision of Medically Necessary BHT services and must coordinate with LEAs, RCs, and other entities that provide BHT services to ensure that Members timely receive all Medically Necessary BHT services, consistent with the EPSDT benefit. Contractor must provide Medically Necessary BHT services across settings, including home, school, and in the community, that are not duplicative of BHT services actively provided by another entity. Contractor must coordinate with, and make good faith attempts to enter into Memorandum of Understandings (MOUs) with RCs and LEAs, and Contractor must enter into MOUs with County Mental Health Plans (MHPs) in accordance with Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*), to facilitate the coordination of services for Members with Developmental Disabilities, including Autism Spectrum Disorder (ASD), as permitted by federal and State law, and specified by DHCS in APL 22-005 and APL 22-006. If Contractor is unable to enter into an MOU or a one-time case agreement with a RC, Contractor must inform DHCS why it could not reach an agreement with the RC and must demonstrate, by providing all evidence of contracting efforts, a good faith effort to enter into an agreement with the RC.

G. Local Education Agency Services

Contractor must reimburse LEAs, as appropriate, for the provision of school-linked EPSDT services including but not limited to BHT as specified in Exhibit A, Attachment III, Subsection 4.3.16 (*School-Based Services).*

H. Rapid Whole Genome Sequencing

Back to Agenda Back to Item

Rapid whole genome sequencing, including individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing, is a Covered Service for any Medi-Cal Member who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit as required in W&I section 14132(a)(e).

5.3.5 Services for Adults

A. Initial Health Appointment for Adults Ages 21 and over

1) Contractor must cover and ensure that IHAs for adult Members are performed within 120 calendar days of Enrollment.

2) Contractor must ensure that the IHA for adults includes, but is not limited to, an evaluation of applicable preventive services provided in accordance with the United States Preventive Services Taskforce (USPSTF) grade A and B recommendations.

B. Adult Preventive Services

Contractor must cover and ensure the provision of all preventive services and Medically Necessary diagnostic and treatment services for adult Members as follows:

1) Contractor must ensure provision of all applicable preventive services identified as USPSTF grade A and B recommendations for adult Members in accordance with the Guide to Clinical Preventive Services published by the USPSTF.

2) Contractor must cover and ensure the provision of all Medically Necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the IHA, or during visits for routine, urgent, or emergent health care situations. Contractor must ensure that these services are initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow up.

3) Contractor must comply with APL 22-025 and ensure the provision of an annual cognitive health assessment for Members who are 65 years of age or older and are otherwise ineligible to receive a similar assessment as part of a Medicare annual wellness visit.

C. Immunizations

1) Contractor must cover vaccinations, except for vaccinations expressly excluded by DHCS in guidance to Medi-Cal Managed Care Health Plans, at the time of any health care visit and ensure the timely provision of vaccines in accordance with the most recent adult immunization schedule and recommendations published by the ACIP. Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the vaccination will be considered sufficient in meeting this requirement.

2) In addition, Contractor must cover and ensure the provision of age and risk appropriate vaccinations in accordance with the findings of the IHA, or other preventive screenings.

3) At each non-emergency Primary Care Encounter the Member must be advised of the vaccinations due and available from Contractor, if the Member has not received vaccinations in accordance with ACIP standards. Documentation must be entered in the Member's Medical Record which indicates the receipt of vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation must be entered in the Member's Medical Record which indicates the vaccinations were advised, and the Member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is required that the Medical Record must demonstrate that the Member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations.

4) Contractor must ensure that Member-specific vaccination information is reported to immunization registries established in Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports will be made following the Member's IHA and all other health care visits that result in an administered vaccine within 14 calendar days. Reporting will be in accordance with all applicable State and federal laws.

5.3.6 Pregnant and Postpartum Members

A. Prenatal and Postpartum Care

Contractor must cover and ensure the provision of all Medically Necessary services for Members who are pregnant and postpartum. Contractor must utilize the most current standards or guidelines of American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Perinatal

Services Program (CPSP) to ensure Members receive quality perinatal and postpartum services.

B. Risk Assessment

Contractor must implement a comprehensive risk assessment tool for all pregnant Members that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348. Contractor must maintain the results of this assessment as part of the Member's obstetrical record, which must include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. If administration of the risk assessment tool is missed at the appropriate timeframes, then Contractor must ensure case management and Care Coordination are working directly with the Member to accomplish the assessment. Contractor must follow up on all identified risks with appropriate interventions consistent with ACOG standards and CPSP standards and document those interventions in the Member's Medical Record. The risk assessment may be completed virtually through a Telehealth visit with the Member's consent.

C. Referral to Specialists

Contractor must ensure that pregnant Members are referred to medically appropriate Specialists, including, as appropriate, perinatologists, Freestanding Birthing Centers, Certified Nurse Midwives (CNMs), Licensed Midwives, and, are informed about Doula coverage. Pregnant Members may request and receive a recommendation for Doula services from a physician or other licensed practitioner of the healing arts acting within their scope of practice under State law and receive services. Contractor must ensure that pregnant and postpartum Members receive a recommendation for Doula services within one year after pregnancy, if requested by the Member, and must ensure access to genetic screening with appropriate referrals. Members may receive one initial visit; eight visits at any time during the perinatal period; services during labor and delivery, miscarriage, or abortion; and two extended postpartum visits with the standing recommendation issued by DHCS. An additional nine visits during the postpartum period is available with a second recommendation from a licensed provider. Contractor must comply with section 440.130(c) of Title 42 of the Code of Federal Regulations when making a recommendation for Doula services. Doula services are a preventive benefit for Medi-Cal Members, and services include but are not limited to

Back to Agenda Back to Item

personal support to pregnant individuals and families throughout pregnancy, labor, and the postpartum period. Contractor must also ensure that appropriate hospitals are available within the Network to provide necessary high-risk pregnancy services.

5.3.7 Services for All Members

A. Health Education

1) Contractor must implement and maintain a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion, and patient education for all Members.

2) Contractor must ensure administrative oversight of the health education system by a qualified full-time health educator.

3) Contractor must provide evidence-based health education programs and services to Members, directly, or through Subcontractors, Downstream Subcontractors, or Network Providers.

4) Contractor must ensure organized delivery of health education programs using educational strategies and methods that are appropriate for Members and effective in achieving behavioral change for improved health. Contractor may offer Members non-monetary incentives for participating in incentive programs, focus groups, and Member surveys authorized by W&I section 14407.1 pursuant to APL 16-005.

5) Contractor must ensure that health education materials are written at the sixth-grade reading level and are culturally and linguistically appropriate for the intended audience in accordance with APL 18-016. Contractor must review health education materials to ensure documents are up-to-date.

6) Contractor must ensure availability of Community Health Workers (CHWs) to all Members. CHWs should provide services to include but are not limited to assisting Members with health care system navigation, communicating cultural and language preferences to providers, accessing health care services, educating health needs, and connecting individuals and families with community-based resources.

7) Contractor must maintain a health education system, or use a DHCS-sponsored system if available, that provides educational interventions addressing health categories and topics that align with the Population Health Management (PHM) Strategy, in accordance with Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), including education regarding the appropriate use of health care services, risk-reduction and healthy lifestyles, and self-care and management of health conditions.

8) Contractor must ensure that Members receive point of service education as part of preventive and primary health care visits. Contractor must provide education, training, and program resources to Network Providers for the delivery of health education services.

9) Contractor must maintain health education policies, procedures, standards, and guidelines. Contractor must maintain documentation that demonstrates effective implementation of the health education requirements.

10) Contractor must monitor the health education system including accessibility for Limited English Proficient (LEP) Members and the performance of Providers that are contracted to deliver health education services. Contractor must ensure appropriate allocation of health education resources and conduct appropriate levels of program evaluation.

B. Hospice Care

1) Contractor must cover and ensure the provision of hospice care services as defined in 42 USC section 1396d(o)(1) and as required by APL 13-014. Contractor must ensure that Members and their families are fully informed of the availability of hospice care as a Covered Service and the methods by which they may elect to receive these services. In accordance with APL 13-014, a hospice must obtain written certification of terminal illness for each hospice benefit period. “Terminally ill,” as defined in 42 CFR section 418.3, means that an individual has a medical prognosis that their life expectancy is six months or less if the illness runs its normal course. Services are limited to Members who directly or through their AR voluntarily elect to receive hospice care in lieu of other care as specified. However, for Members less than 21 years of age, a voluntary election of hospice care does not constitute a waiver of

any rights of that Member to be provided with, or to have payment made for, Covered Services that are related to the treatment of that Member's condition for which a diagnosis of terminal illness has been made.

2) For Members who have elected hospice care, Contractor must arrange for continuity of care, including maintaining established patient-Provider relationships, to the greatest extent possible. Contractor must cover the cost of all hospice care provided. Contractor must also cover all Medically Necessary care not related to the terminal condition.

C. Palliative Care

Contractor must cover and ensure the provision of palliative care, as required by W&I section 14132.75 and as set forth in APL 18-020, and as required for Members less than 21 years of age under the EPSDT benefit and standard of Medical Necessity. Contractor must continue to cover all Medically Necessary Covered Services for Members receiving palliative care. For Members less than 21 years of age, Contractor must cover palliative care concurrently with hospice care and other Medically Necessary Covered Services if hospice care is elected by the Member.

D. Vision Care – Lenses

Contractor must cover and ensure the provision of eye examinations to include screening examinations and prescriptions for corrective lenses as appropriate for all Members. Contractor must arrange for the fabrication of optical lenses for Members through Prison Industry Authority (PIA) optical laboratories except when the Member requires lenses not available through PIA. Contractor must cover the cost of the eye examination and dispensing of the lenses fabricated by PIA. DHCS will reimburse PIA for the fabrication of the optical lenses in accordance with the contract between DHCS and PIA. Contractor must cover the cost of fabrication and dispensing of lenses not available through PIA.

E. Mental Health and SUD Services

Contractor must cover all Medically Necessary mental health and SUD services specified in Exhibit A, Attachment III, Subsection 5.5.2 (*Non-specialty Mental Health Services and Substance Use Disorder Services*) in compliance with mental health parity requirements in 42 CFR section 438.900 *et seq*., and Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*).

F. Organ and Bone Marrow Transplant Surgeries

Contractor must cover all Medically Necessary organ and bone marrow transplant surgeries as set forth in the Medi-Cal Provider Manual, including all updates and amendments to the Manual.

1) Contractor must refer and authorize organ and bone marrow transplant surgeries to be performed in transplant programs that meet criteria set forth by DHCS in the Medi-Cal Provider Manual.

2) Contractor must authorize and cover costs for organ or bone marrow transplants for Members. Contractor must cover all pre and post-operative transplant-related costs such as, but not limited to, evaluation, hospitalization, and all Medically Necessary services such as transportation and prescriptions not covered by and billable to Medi-Cal Rx.

3) Contractor must refer Members identified as potential organ or bone marrow transplant candidates to a transplant program evaluation that meets criteria set forth by DHCS within 72 hours of receiving the referral. If the transplant program considers the Member to be a suitable transplant candidate, Contractor must authorize the request for transplant services on an expedited 72-hour basis or less if the Member's condition requires it, or if the organ or bone marrow the Member will receive is at risk of being unusable due to any delay in obtaining Prior Authorization or any delay in obtaining the organ or bone marrow.

4) Contractor must refer Members less than 21 years of age identified as a potential organ or bone marrow transplant candidate to the local CCS Program for eligibility determination, if necessary, unless Contractor is responsible for the CCS benefit (Whole Child Model contracts only). Major Organ Transplants (MOT) for Members less than 21 years of age must be performed only in a CCS-approved Special Care Center (SCC) or DHCS-approved Transplant Centers of Excellence. If the CCS Program determines that the Member is not eligible for the CCS Program or the MOT is not related to the Member's CCS eligible medical condition, but the MOT is Medically Necessary, Contractor must refer the Member to a transplant program within 72 hours of receipt of the eligibility determination and is responsible for authorizing the MOT, as appropriate.

5) Contractor must refer CCS-eligible Members less than 21 years of age to the appropriate CCS-approved Special Care Center that meets criteria set forth by DHCS within 72 hours of receiving the referral from the Member's PCP or Specialist identifying the Member as a transplant candidate. If the CCS-approved Special Care Center considers the Member to be a suitable transplant candidate, Contractor is required to approve the Prior Authorization request.

6) For Members less than 21 years of age, Contractor must provide Prior Authorization for requests for transplant services on an expedited, 72-hour basis, or less if the Member's condition requires it or if the organ or bone marrow the Member will receive is at risk of being unusable due to any delay in obtaining Prior Authorization or any delay in obtaining the organ or bone marrow.

7) Contractor must authorize and cover costs for organ or bone marrow donors, including cadavers and living donors regardless of a living donor's Medi-Cal eligibility. Contractor must cover transplant-related costs such as evaluation, hospitalization for the living donor, organ or bone marrow removal, and all Medically Necessary services related to organ or bone marrow removal including complications, transportation, and prescriptions not covered by and billable to Medi-Cal Rx.

8) Contractor must ensure coordination of care between all Providers, organ or bone marrow donation entities, and transplant centers to ensure the transplant is completed as expeditiously as possible. This coordination of care must include care for all living donors.

9) Contractor must ensure the provision of Discharge Planning as defined in this Contract for Members and living donors.

10) Contractor must cover all readmissions and other health care costs related to any complications the Member or the living donor experiences from the organ or bone marrow transplant.

11) Contractor must cover all Medically Necessary physician administered drugs provided to a Member or the living donor administered by a health care professional in a clinic, physician's office, or outpatient setting and is needed for the Member receiving an organ or bone marrow transplant, such as anti-rejection medication, and any other Medically Necessary Prescription Drug not covered by Medi-Cal Rx.

Back to Agenda Back to Item

G. Long-Term Care Services

Contractor must authorize and cover Long-Term Care (LTC) services as set forth in APL 23-004, APL 23-023, and APL 23-027. Contractor must ensure that Members in need of LTC services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs, unless the Member has elected hospice care.

1) Contractor must ensure that Members, other than Members requesting hospice services, in need of LTC services are placed in a LTC facility that provides the level of care most appropriate to the Member's medical needs. Contractor must make Member placement decisions based on the appropriate level of care, as set forth in the definitions in 22 CCR sections 51118, 51120, 51120.5, 51121, 51123, 51124, 51124.5, and 51124.6, W&I section 14132.25 and the criteria for admission set forth in 22 CCR sections 51335, 51335.5, 51335.6, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in 22 CCR section 51003(e).

2) Contractor must place Members in LTC facilities that are licensed and certified by the California Department of Public Health (CDPH). Contractor must ensure that contracted LTC facilities have not been decertified by CDPH or otherwise excluded from participation in the Medi-Cal Program.

3) Contractor must provide continuity of care to Members through continued access to the LTC facility in which the Member is residing at time of Enrollment for up to 12 months. During this time, Contractor may attempt to place Members at LTC facilities within its Network only with approval from the Member or individual authorized to make health care decisions on their behalf.

4) Contractor must cover a Member stay in a facility with availability regardless of Medical Necessity if placement in a Medically Necessary appropriate lower level of care is not available, unless otherwise provided by contract. Contractor must continue to attempt to place the Member in a facility with the appropriate level of care, including offering to contract with facilities within and outside of the Service Area.

5) Contractor must provide Transitional Care Services as specified in Exhibit A, Attachment III, Subsection 4.3.11 (*Targeted Case Management Services*).

6) Hospice Services as defined in 22 CCR section 51180 rendered in a Skilled Nursing Facility (SNF) or Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF~~D~~/DD-H), and ICF/DD-Nursing (ICF/DD-N) homes are not LTC services consistent with 22 CCR section 51544(h).

7) Contractor must ensure that Members in need of ICF/DD, ICF/DD-H, and ICF/DD-N services are placed in the ICF/DD Home deemed most appropriate to the Member's medical needs as specified in the Individualized Program Plan (IPP) issued by the Member's Regional Center.

H. Pharmaceutical Services

1) Drug Use Review (DUR)

Contractor must develop and implement effective DUR and treatment outcome process, as directed in APL 17-008, APL 23-026, and APL 22-012 (excluding prospective DUR activities), to ensure that drug utilization is appropriate, Medically Necessary, and not likely to result in adverse events.

a) Contractor's DUR must meet or exceed the requirements described in 42 USC section 1396r-8(g) and 42 CFR section 438.3(s), to the extent that Contractor provides covered outpatient drugs, and Section 1004 requirements of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patient and Communities Act.

b) Contractor's DUR must implement:

i. A retrospective claims review automated process that monitors when a Member is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics;

ii. A program to monitor and manage the appropriate use of antipsychotic medications by all Children 18 years of age and under including foster Children

enrolled under the California Medicaid State Plan, as required in 42 USC section 1396a(oo)(1)(B), APL 23-026, and APL 22-012; and

iii. Fraud and abuse identification processes for potential Fraud or abuse of controlled substances by Members, Providers, and pharmacies.

c) Contractor must annually submit to DHCS a detailed report in a format specified by DHCS on their DUR Program activities.

2) Contractor must not impose Quantitative Treatment Limitation (QTL) or Non-Quantitative Treatment Limitation (NQTL) more stringently for mental health and SUD drugs prescriptions than for medical/surgical drugs, in accordance with 42 CFR section 438.900 *et seq*.

I. Transportation

Contractor must cover transportation services as required in this Contract and directed in APL 22-008 to ensure Members have access to all Medically Necessary services.

1) Contractor must cover Emergency Medical Transportation (EMT) services necessary to provide access to all emergency Covered Services.

2) Contractor must cover NEMT services necessary for Members to access Covered Services, subject to a prescription and Prior Authorization when required, in accordance with 22 CCR section 51323.

a) Contractor must require Members to have an approved Physician Certification Statement (PCS) form prescribing NEMT by their provider, as described in APL 22-008, before Prior Authorization can be granted for NEMT services, except as provided in 22 CCR section 51323 (b)(2)(A),(C). For Covered Services requiring recurring appointments, Contractor must provide authorization for NEMT for the duration of the recurring appointments, not to exceed 12 months, and ensure the Member has a standing order guaranteeing assigned rides for the duration of the recurring

Back to Agenda Back to Item

appointments. Contractor cannot modify the form once the provider prescribes the mode of NEMT.

b) Contractor must refer and coordinate NEMT services for Medi-Cal services that are not covered under the Contract. However, Contractor must provide NEMT services for their Members for all pharmacy prescriptions prescribed by the Member's Medi-Cal provider(s) and those authorized under Medi-Cal Rx.

c) Contractor must have a process in place to ensure transportation brokers and providers are meeting these requirements and to impose corrective action if non-compliance is identified through oversight and monitoring activities.

3) As provided for in W&I section 14132(ad), Contractor must authorize all NMT for Members to obtain Covered Services in accordance with the requirements and guidelines set forth in APL 22-008. Nothing in this provision will be construed to prohibit Contractor from developing policies and procedures that may include reasonable Utilization Management procedures for NMT. Contractor must also provide NMT for all Medi-Cal services not covered under this Contract. These services include, but are not limited to, Specialty Mental Health Service (SMHS), SUD services, dental, pharmacy, pharmaceutical services, and any other benefits delivered through Medi-Cal FFS.

4) Contractor must provide NEMT or NMT for a parent, legal guardian, or AR when the Member is a minor. With the written consent of a parent, legal guardian, or AR, Contractor may arrange NEMT or NMT services for a minor who is unaccompanied by a parent, legal guardian, or AR. Contractor must provide transportation services for unaccompanied minors when applicable State or federal law does not require parental consent for the minor's service. Contractor must ensure all necessary written consent forms are collected prior to arranging transportation for an unaccompanied minor and cannot arrange NEMT or NMT services for an unaccompanied minor without the necessary consent forms unless State or federal law does not require parental consent for minor's service.

5) Consistent with 42 CFR sections 440.170(a) and 431.53, W&I section 14132(a) and (d), and APL 22-008, Contractor must also

cover transportation-related travel expenses for Members obtaining Medically Necessary services. Transportation-related travel expenses are subject to retroactive reimbursement.

J. Care Management and Care Coordination

1) Contractor must provide all Members with Care Coordination services as specified in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*).

2) Contractor must provide care management services to all Members as specified in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*) and Exhibit A, Attachment III, Subsection 4.3.7 (*Care Management Programs*). Care management services include, Basic Population Health Management (Basic PHM), Complex Care Management (CCM), and Enhanced Care Management (ECM).

K. Dyadic Services

Contractor must provide Dyadic Services and the Family Therapy benefit for Members less than 21 years of age and/or their caregivers in an outpatient setting as Medically Necessary as set forth in APL 22-029 and detailed below.

1) Dyadic Services may be provided by Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners, and Psychiatrists. Associate Marriage and Family Therapists, Associate Professional Clinical Counselors, Associate Clinical Social Workers, and Psychology Assistants may render services under a supervising clinician. Appropriately trained nonclinical staff, including CHWs, are not precluded from screening Members for issues related to SDOH or performing other nonclinical support tasks as a component of the Dyadic Behavioral Health (DBH) visit, as long as the screening is not separately billed.

a) Under the supervision of a supervising Provider from one of the provider types listed above, CHWs can assist a dyad to gain access to needed services to support their health through the CHW benefit for health navigation services.

Back to Agenda Back to Item

b) Contractor is responsible for ensuring appropriate supervision of Dyadic Services Providers and educating all Network Providers on the Dyadic Services benefit.

2) Member Eligibility for Dyadic Services

a) Children and their parent(s)/ caregiver(s) are eligible for DBH well-Child visits when delivered according to the Bright Futures/American Academy of Pediatrics periodicity schedule for behavioral/social/emotional screening assessment, and when medically necessary, in accordance with Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards in 42 USC section 1396d(r).

i. Under EPSDT standards, a diagnosis is not required to qualify for services.

ii. The DBH well-Child visits do not need a particular recommendation or referral and must be offered as an appropriate service option even if the Member does not request them.

b) The family is eligible to receive Dyadic Services so long as the Child is enrolled in Medi-Cal. The parent(s) or caregiver(s) does not need to be enrolled in Medi-Cal or have other coverage so long as the care is for the direct benefit of the Child.

3) Covered Services

a) Contractor may offer the Dyadic Services benefit through Telehealth or in-person with locations in any setting including, but not limited to, pediatric Primary Care settings, doctor's offices or clinics, inpatient or outpatient settings in hospitals, the Member's home, school-based sites, or community settings. There are no Service Location limitations.

b) Covered Dyadic Services are Behavioral Health Services for Children and/or their parent(s) or caregiver(s), and include:

i. DBH Well-Child Visits

Back to Agenda Back to Item

a. The DBH well-Child visit must be limited to those services not already covered in the medical well-Child visit.

b. When possible and operationally feasible, the DBH well-Child visit should occur on the same day as the medical well-Child visit. When this is not possible, Contractors must ensure the DBH well-Child visit is scheduled as close as possible to the medical well-Child visit, consistent with timely access requirements.

c. Contractor may deliver DBH well-Child visits as part of the HealthySteps program, a different DBH program, or in a clinical setting without a certified DBH program as long as all of the following components are included:

    aa. Behavioral Health history for Child and parent(s) or caregiver(s), including parent(s) or caregiver(s) interview addressing Child's temperament, relationship with others, interests, abilities, and parent or caregiver concerns.

    bb. Developmental history of the Child.

    cc. Observation of behavior of Child and parent(s) or caregiver(s) and interaction between Child and parent(s) or caregiver(s).

    dd. Mental status assessment of parent(s) or caregiver(s).

    ee. Screening for family needs, which may include tobacco use, substance use, utility needs, transportation needs, and interpersonal safety, including guns in the home.

    ff. Screening for SDOH such as poverty, food insecurity, housing instability,

access to safe drinking water, and community level violence.

gg. Age-appropriate anticipatory guidance focused on Behavioral Health promotion/risk factor reduction.

hh. Making essential referrals and connections to community resources through Care Coordination and helping caregiver(s) prioritize needs.

ii. Dyadic Comprehensive Community Supports Services, separate and distinct from the California Advancing and Innovating Medi-Cal (CalAIM) Community Supports, help the Child and their parent(s) or caregiver(s) gain access to needed medical, social, educational, and other health-related services, and may include any of the following:

a. Assistance in maintaining, monitoring, and modifying covered services, as outlined in the dyad's service plan, to address an identified clinical need.

b. Brief telephone or face-to-face interactions with a person, family, or other involved member of the clinical team, for the purpose of offering assistance in accessing an identified clinical service.

c. Assistance in finding and connecting to necessary resources other than covered services to meet basic needs.

d. Communication and coordination of care with the Child's family, medical and dental health care Providers, community resources, and other involved supports including educational, social, judicial, community and other State agencies.

e. Outreach and follow-up of crisis contacts and missed appointments.

f. Other activities as needed to address the dyad's identified treatment and/or support needs.

c) Dyadic Psychoeducational Services for psychoeducational services provided to the Child less than 21 years of age and/or parent(s) or caregiver(s). These services must be planned, structured interventions that involve presenting or demonstrating information with the goal of preventing the development or worsening of Behavioral Health conditions and achieving optimal mental health and long-term resilience.

d) Dyadic Family Training and Counseling for Child Development for family training and counseling provided to both the Child less than 21 years of age and parent(s) or caregiver(s). These services include brief training and counseling related to a Child's behavioral issues, developmentally appropriate parenting strategies, parent/Child interactions, and other related issues.

e) Dyadic Parent or Caregiver Services

Dyadic parent or caregiver services are services delivered to a parent or caregiver during a Child's visit that is attended by the Child and parent or caregiver, including the following assessment, screening, counseling, and brief intervention services provided to the parent or caregiver for the benefit of the Child as appropriate:

i. Brief Emotional/Behavioral Assessment

ii. ACEs Screening

iii. Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment

iv. Depression Screening of Health Behavior Assessments and Interventions

v. Psychiatric Diagnostic Evaluation

vi. Tobacco Cessation Counseling

4) Family Therapy as a Behavioral Health Benefit

a) Family therapy is type of psychotherapy covered under Medi-Cal's NSMHS benefit, including for Members less than 21 years of age who are at risk for Behavioral Health concerns and for whom clinical literature would support that the risk is significant such that Family Therapy is indicated, but may not have a mental health diagnosis. The primary purpose of Family Therapy is to address family dynamics as they relate to the Member's mental status and behavior(s).

b) Family Therapy is composed of at least two family members receiving therapy together provided by a mental health Provider to improve parent/Child or caregiver/Child relationships and encourage bonding, resolving conflicts, and creating a positive home environment.

c) All family members do not need to be present for each service. For example, parents or caregivers can qualify for Family Therapy without their infant present, if necessary.

d) Both Children and adult Members can receive Family Therapy mental health services that are medically necessary. Contractor is required to provide Family Therapy to the following Medi-Cal Members to improve parent/Child or caregiver/Child relationships and bonding, resolve conflicts, and create a positive home environment:

i. Members less than 21 years of age with a diagnosis of a mental health disorder;

ii. Members less than 21 years of age with persistent mental health symptoms in the absence of a mental health disorder;

iii. Members less than 21 years of age with a history of at least one of the following risk factors:

a. Neonatal or pediatric intensive care unit hospitalization;

b. Separation from a parent or caregiver (for example, due to incarceration, immigration, or military deployment);

c. Death of a parent or caregiver of Foster home placement;

d. Food insecurity, housing instability;

e. Maltreatment;

f. Severe and persistent bullying; and

g. Experience of discrimination, including but not limited to discrimination on the basis of race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disability;

iv. Members less than 21 years of age who have a parent(s) or caregiver(s) with one or more of the following risk factors:

a. A serious illness or disability;

b. A history of incarceration;

c. Depression or other mood disorder;

d. Post-Traumatic Stress Disorder or other anxiety disorder;

e. Psychotic disorder under treatment;

f. SUD;

g. Job loss;

h. A history of intimate partner violence or interpersonal violence; and

i. Is a teen parent.

e) Contractor must provide Family Therapy services if needed to correct or ameliorate a Child's mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the condition and are thus covered as EPSDT services.

f) Members less than 21 years of age may receive up to five Family Therapy sessions before a mental health diagnosis is required. Contractor must provide Family Therapy without regard to the five-visit limitation for Members less than 21 years of age with risk factors for mental health disorders or parents/caregivers with related risk factors, including separation from a parent/caregiver due to incarceration, immigration, or death; foster care placement; food insecurity; housing instability; exposure to domestic violence or trauma; maltreatment; severe/ persistent bullying; and discrimination.

5) Billing and Claims

a) Dyadic Services Providers must be reimbursed in accordance with their Network Provider contract.

b) Contractor must not require Prior Authorization for Dyadic Services.

c) Contractor must not establish unreasonable or arbitrary barriers for accessing coverage.

d) Encounters for Dyadic Services must be submitted with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.

e) Multiple Dyadic Services are allowed on the same day and may be reimbursed at the FFS rate.

f) The DBH well-Child visit must be limited to those services that are not already covered in the medical well-Child visit, and any other service codes cannot be duplicative of services that have already provided in a medical well-Child visit or a DBH well-Child visit.

Back to Agenda Back to Item

g) Dyadic caregiver service codes (screening, assessment, and brief intervention services provided to the parent or caregiver for the benefit of the Child) may be billed by either the medical well-Child Provider or the DBH well-Child visit Provider, but not by both Providers, when the dyad is seen on the same day by both Providers.

h) Tribal Health Programs, Rural Health Clinics (RHCs), and Federal Qualified Health Centers (FQHCs) are eligible to receive their All-Inclusive Rate from Contractor if Dyadic Services are provided by a billable Provider per APL 17-002 and APL 21-008.

i. Dyadic Services may be reimbursed at the FFS rate established for services, if the service provided does not meet the definition of a THP, RHC, or FQHC visit, or exceeds frequency limitations.

ii. THP, RHC, and FQHC Providers can bill FFS for Dyadic Services delivered in a clinical setting by Provider types named in the Non-specialty Mental Health Services: Psychiatric and Psychological Services section of the Medi-Cal Provider Manual.

iii. THP, RHC, and FQHC Providers cannot double bill for Dyadic Services that are duplicative of other services provided through Medi-Cal.

iv. All Dyadic Services must be billed under the Medi-Cal identity of the Member less than 21 years of age.

L. Practice Guidelines

Contractor must adopt practice guidelines in accordance with 42 CFR section 438.236, and this Contract. Contractor's decisions for Utilization Management, Member education, provision of Covered Services, and other areas covered by practice guidelines must be consistent with these guidelines. Contractor must also provide their practice guidelines, upon request, to Members and Potential Members.

M. Asthma Preventive Services

Contractor must ensure availability of Asthma Preventive Services (APSs), including clinic-based and home-based asthma self-education, and in-

Back to Agenda Back to Item

home environmental trigger assessments for all Members with a diagnosis of asthma. APSs may be provided by a Physician or a Non-Physician Medical Practitioner, or a licensed practitioner of the healing arts within their scope of practice. APSs may also be provided by unlicensed Providers, which may include CHW, who have met the qualifications of an APS Provider and are providing these services under a supervising Physician or Non-Physician Medical Practitioner, clinic, hospital, local health jurisdiction, or community-based organization.

N. Community Health Workers Services

1) Contractor must ensure availability of CHW Services to all Members that meet the eligibility criteria in accordance with 42 CFR section 440.130(c).

2) Contractor must adhere to DHCS guidance on service definitions, eligible populations, and CHW Provider parameters as stated in APL 22-016.

a) CHW services are defined as preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs may include individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified below.

b) CHW services are considered Medically Necessary for Members with one or more chronic health conditions (including Behavioral Health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services.

3) CHW Provider and Supervising Provider Requirements

a) Contractor must determine, verify, and validate CHW Providers can provide CHW Services in an effective manner consistent with culturally and linguistically appropriate care.

b) CHW Providers must have lived experience that aligns with and provides a connection between CHW and the Member population being served in.

c) CHWs must have lived experience that aligns with and provides a connection between the CHW and the Member or population being served. This may include, but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

d) Contractor must contract with a Supervising Provider to oversee CHW providers and the services delivered to Members. CHW providers can be supervised by a community-based organization (CBO) or a local health jurisdiction (LHJ) that does not have a licensed Provider on staff in alignment with the Provider Manual and APL 22-016.

e) Contractor must ensure that Network Providers and Subcontractors contracting with or employing CHWs to provide Covered Services have adequate supervision and training.

f) Contractor must ensure CHW Providers demonstrate, and Supervisor Providers maintain evidence of, minimum qualifications through the CHW certificate pathway, Violence Prevention certificate pathway, or Work experience pathway.

g) Certificate Pathway: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates: o CHW Certificate: A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment,

Back to Agenda Back to Item

professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and Social Drivers of Health (SDOH), as determined by the Supervising Provider. 6 Certificate programs must also include field experience as a requirement. A CHW Certificate allows a CHW to provide all covered CHW services described in this APL, including violence prevention services.

h) Violence Prevention Professional Certificate: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training form the Urban Peace Institute. 7,8 A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or by completion of a General Certificate.

i) Work Experience Pathway: An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and has demonstrated skills and practical training in the areas described above, as determined and validated by the Supervising Provider, may provide CHW services without a certificate of completion for a maximum period of 18 months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Member.

j) Contractor must have a process for verifying qualifications and experience of Supervising Providers, which must extend to individuals employed by, or delivering CHW Services on behalf of, the Supervising Provider.

k) Contractor must ensure Supervising Providers and CHW Providers comply with all applicable State and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and PLs.

O. Community Health Workers Provider Capacity

1) Contractor must ensure and monitor appropriate, adequate Networks within its Service Area, including for CHW Services as stated in APL 21-006.

2) Contractor must use data-driven approaches to determine and understand priority populations eligible for CHW Services, including but not limited to, using past and current Member utilization/encounters, frequent hospital admissions or emergency department visits, demographic and Social Drivers of Health data, referrals from the community, and needs assessments.

P. Identifying Members for Community Health Workers

1) Contractor must require a referral for CHW Services submitted by a Physician or other licensed practitioner of the healing arts within their scope of practice under State law.

2) Contractor must accept recommendations for CHW Services from other licensed practitioners, whether they are in the Network or out-of-Network Providers, within their scope of practice, including physician assistants, nurse practitioners, clinical nurse Specialists, podiatrists, nurse midwives, Licensed Midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.

Q. Cancer Biomarker Testing

Contractor must comply with APL 22-010 and cover Medically Necessary biomarker testing for Members with advanced or metastatic stage 3 or 4 cancer and cancer progression or recurrence in the Member with advanced or metastatic stage 3 or 4 cancer. Contract is prohibited from imposing Prior Authorization requirements on biomarker testing that is associated with a federal Food and Drug Administration (FDA)-approved therapy for advanced or metastatic stage 3 or 4 cancer.

R. COVID-19 Coverage

Contractor must cover COVID-19 related services to include prevention, testing, and treatment as detailed in APL 22-009.

5.3.8 Investigational Services

A. Contractor must cover investigational services as defined in 22 CCR section 51056.1(b) when a service is determined to be investigational pursuant to 22 CCR section 51056.1(c), and all requirements in 22 CCR section 51303(h) are met and documented in the Member's Medical Record.

B. Routine Patient Care Costs for Clinical Trials

1) Contractor must cover routine patient care costs for Members participating in a qualifying clinical trial including items and services furnished in connection with participation by Members in a qualifying clinical trial pursuant to 42 USC section 1396d(a)(30), and W&I section 14132.98. A qualifying clinical trial is a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition.

2) Routine patient care costs are costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the Medi-Cal program if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program.

3) Coverage of routine patient care costs must be provided regardless of geographic location or if the treating Provider or principal investigator of the qualifying clinical trial is a Network Provider.

4) Coverage of routine patient care costs must be based on Provider’s and principal investigator’s approval regarding the Member’s appropriateness for the qualifying clinical trial.

5) The coverage determination must be expedited and completed within 72 hours.

6) Contractor must require the submission of the “Medicaid Attestation Form on the Appropriateness of the Qualifying Clinical Trial” for approval of the clinical trial. The attestation form must include the following information:

a) The Member’s name and client identification number;

b) The national clinical trial number;

Back to Agenda Back to Item

c) A statement signed by the principal investigator attesting to the appropriateness of the qualified clinical trial; and

d) A statement signed by the Provider attesting to the appropriateness of the qualified clinical trial.

Exhibit A, ATTACHMENT III

5.4 Community Based Adult Services

5.4.1 Covered Services
5.4.2 Coordination of Care
5.4.3 Required Reports for the Community Based Adult Services Program
5.4.4. Community Participation
5.4.5. Community Based Adult Services Program Integrity

5.4 Community Based Adult Services

5.4.1 Covered Services

In addition to Exhibit A, Attachment III, Section 5.3 (*Scope of Services*), Contractor must cover Community Based Adult Services (CBAS) in accordance with the California Advancing and Innovating Medi-Cal (CalAIM) 1115(a) Demonstration, Number 11-W-00193/9 Special Terms and Conditions (STCs), including Sections V.A.19 through 30 and Attachments H and S, or in accordance with any subsequent demonstration amendment or renewal or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS. Contractor must cover CBAS and ensure provision of the following services:

A. Arrange for the provision of CBAS to Members determined eligible to receive CBAS core services, and additional services as needed, in accordance with the CalAIM STCs Section V.A.20.a and b, Attachment H, and Exhibit A, Attachment III, Subsection 5.4.2.C. (*Coordination of Care*);

B. Consider a Member's relationship with a previous Provider of services similar to CBAS when referring a Member to a CBAS Provider;

C. Cover CBAS as a bundled service through a CBAS Provider or arrange for the provision of unbundled CBAS based on the assessed needs of Members eligible for CBAS if a certified CBAS Provider is not available or not contracted, or there is insufficient CBAS Provider capacity in the area, as required by Exhibit A, Attachment III, Subsection 5.2.8.J. (*Specific Requirements for Access to Programs and Covered Services*). Arranging for unbundled CBAS services includes authorizing Covered Services and coordinating with community resources to assist Members whose CBAS Providers have closed, and Members who have similar clinical conditions as CBAS Members, to remain in the community, in accordance with the following requirements listed below.

1) Unbundled CBAS Covered Services are limited to the following:

a) Professional Nursing Services;

b) Nutrition;

c) Physical Therapy;

d) Occupational Therapy;

e) Speech and Language Pathology Services;

f) Nonmedical Emergency Transportation (NEMT) and Non-Medical Transportation (NMT), only between the Member's home and the CBAS unbundled service Provider; and

g) Non-specialty Mental Health Services (NSMHS) and Substance Use Disorder (SUD) services that are Covered Services;

2) Contractor must coordinate care for unbundled CBAS services that are not Covered Services based on the assessed needs of the Member eligible for CBAS, including:

a) Personal Care Services;

b) Social Services;

c) Physical and Occupational Maintenance Therapy;

d) Meals;

e) Specialty Mental Health Services (SMHS); and

f) SUD Services

D. Ensure that Member access to Medicare Providers or services is not impeded or delayed through Contractor's provision of CBAS; and

E. Ensure continuity of care, in accordance with Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), when Members switch Medi-Cal managed care plans and/or transfer from one CBAS Provider to another.

F. Arrange for the provision of CBAS Emergency Remote Services (ERS), in response to a Member's needs, and in accordance with CalAIM STCs Section V.A.21 and All Plan Letter (APL) 22-020. CBAS ERS must be provided in alternative Service Locations and/or via Telehealth, including telephone or virtual video conferencing, as clinically appropriate.

1) The circumstances for ERS are time-limited and vary based on the unique and identified needs documented in the Member's Individualized Health and Support Plan (IHSP). Contractor must assess Members at least every three months for ERS as part of the

reauthorization of the Member's Individual Plan of Care (IPC) and review for continued need for ERS.

2) Telehealth delivery of ERS must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, and the methodology must be approved by Contractor. Contractor must demonstrate compliance with the Electronic Visit Verification (EVV) System requirements for personal care services and home health services in accordance with section 12006 of the 21st Century CURES Act and APL 22-014.

3) Contractor must provide ERS under the following circumstances:

   a) State or local emergencies as determined by DHCS or Contractor, such as wildfires and power outages, to allow for the provision of ERS prior or subsequent to an official public health emergency declaration as determined by DHCS or Contractor; and

   b) Personal emergencies, such as time-limited illness or injury, crises, or care transitions that temporarily prevent or restrict Members enrolled in CBAS from receiving CBAS in-person at the CBAS Provider location, subject to approval by Contractor.

5.4.2 Coordination of Care

A. Contractor must provide continuity of care to Members through continued access to a CBAS Provider with whom there is an existing relationship for up to 12 months after Member Enrollment. This requirement includes out-of-Network Providers if there are no Quality of Care issues and the Provider will accept Contractor's rate or the Medi-Cal Fee-For-Service (FFS) rate, whichever is higher, as set forth in Exhibit A, Attachment III, Subsection 5.2.12 (*Continuity of Care for Seniors and Persons with Disabilities*).

B. Contractor must ensure that CBAS IPCs are consistent with the Members' overall care plans and goals, based on Person-Centered Planning and completed in accordance with the CalAIM STCs Section V.A.20., "Individual Plan of Care".

C. Contractor must conduct the initial assessment and subsequent reassessments for Members requesting CBAS in accordance with the CalAIM STCs, Sections VIII.A.19.e and 23.b. In addition, Contractor must:

1) Within 30 calendar days from the initial eligibility inquiry request, Contractor must conduct the CBAS eligibility determination using a DHCS-approved assessment tool. CBAS eligibility determinations must include a face-to-face review with the Member by a Registered Nurse with level of care determination experience for Members who have not previously received CBAS through Contractor's Medi-Cal Managed Care Health Plan. Contractor may forgo a face-to-face review if Contractor determined that the Member is clinically eligible for CBAS and needs an expedited start date;

2) Develop and implement an expedited assessment process to determine CBAS eligibility within 72 hours of receipt of a CBAS authorization request for a Member in a hospital or Skilled Nursing Facility (SNF) whose discharge plan includes CBAS, or who is at high risk of admission to a hospital or SNF or faces an imminent and serious threat to their health;

3) Conduct a reassessment, with family involvement, when appropriate, and redetermination of the Member's eligibility for CBAS at least every six months after the initial assessment or up to every 12 months when determined by Contractor to be clinically appropriate. When a Member requests that services remain at the same level or requests an increase in services due to a change in their level of need, contractor may conduct the reassessment using only the Member's CBAS IPC, including any supporting documentation supplied by the CBAS Provider;

4) Notify Members in writing of their CBAS assessment determination in accordance with the timeframes identified in the CalAIM STCs, Section VIII.A.23.b.i. Contractor's written notice must be approved by DHCS and include procedures for Grievances and Appeals in accordance with current requirements identified in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

5) Require that CBAS Providers update a Member's CBAS Discharge Plan of Care and provide a copy to the Member and to Contractor whenever a Member's CBAS services are terminated. The CBAS Discharge Plan of Care must include:

   a) The Member's name and ID number;

Back to Agenda Back to Item

b) The name(s) of the Member's Physician(s);

c) If applicable, the date the Notice of Action denying authorization for CBAS was issued;

d) If applicable, the date the CBAS benefit will be terminated;

e) Specific information about the Member's current medical condition, treatments, and medications;

f) Potential referrals for Medically Necessary services and other services or community resources that the Member may need upon discharge;

g) Contact information for the Member's Case Manager; and

h) A space for the Member or the Member's representative to sign and date the Discharge Plan of Care.

D. Contractor must coordinate with the CBAS Provider to ensure the following:

1) CBAS IPCs are consistent with Members' overall care plans and goals developed by Contractor;

2) Timely exchange of the following coordination of care information: Member Discharge Plan of Care, reports of incidents that threaten the welfare, health and safety of the Member, and Significant Changes in the Member's condition;

3) Clear communication pathways between the appropriate CBAS Provider staff and Contractor staff responsible for CBAS eligibility determinations, service authorizations, and care planning, including identification of the lead care coordinator for Members who have a care team and Utilization Management; and

4) The CBAS Provider receives advance written notification and training prior to any substantive changes in Contractor's policies and procedures related to CBAS.

E. In addition to the requirements for unbundled CBAS contained in Exhibit A, Attachment III, Subsection 5.4.1 (*Covered Services*), and in accordance with Exhibit A, Attachment III, Subsection 5.4.2 (*Coordination of Care*), Contractor must coordinate care for unbundled CBAS that are not

Back to Agenda Back to Item

Covered Services, based on the assessed needs of the Member eligible for CBAS, including:

1) Personal Care Services

2) Social Services

3) Physical and Occupational Maintenance Therapy

4) Meals

5) SMHS

6) SUD services that are not Covered Services.

5.4.3 Required Reports for the Community Based Adult Services Program

Contractor must submit to DHCS the following reports 30 calendar days following the end of each reporting period and in a format specified by DHCS:

A. How many Members have been assessed for CBAS and the total number of Members currently receiving CBAS, either as a bundled or unbundled service, on a quarterly basis;

B. Identification of CBAS Providers added to or deleted from Contractor's Network, and when there is a 5% drop in capacity, in the quarterly Network changes submission required in Exhibit A, Attachment III, Subsection 5.2.13.C. (*Network Reports*);

C. A summary of any complaints surrounding the provision of CBAS; and

D. Reports on the following areas:

1) Appeals related to requesting CBAS and the inability to receive those services or receiving more limited services than requested;

2) Appeals related to requesting a particular CBAS Provider and the inability to access that Provider;

3) Excessive travel times to access CBAS;

4) Grievances regarding CBAS Providers;

5) Grievances regarding Contractor assessment and/or reassessment; and

6) Any reports pertaining to the health and welfare of Members utilizing CBAS.

E. On an annual basis, Contractor must provide a list of its contracted CBAS Providers and its CBAS accessibility standards.

5.4.4. Community Participation

Contractor must ensure that engagement and community participation for Members receiving CBAS is supported to the fullest extent desired by each Member.

5.4.5. Community Based Adult Services Program Integrity

Following a determination that a credible allegation of Fraud exists involving a CBAS Provider, DHCS must notify Contractor of the finding promptly. In addition to the actions required in APL 15-026, Contractor must report to DHCS, in a timeframe and manner specified by DHCS but no less frequently than quarterly, all payments made to the CBAS Provider involved in a credible allegation of Fraud for CBAS benefits provided after the date of notification. DHCS may recoup payments from Contractor in accordance with CalAIM Terms and Conditions, GPR Section V.A.30.b.

Exhibit A, ATTACHMENT III

5.5 Mental Health and Substance Use Disorder Benefits

5.5.1 Mental Health Parity Requirements
5.5.2 Non-specialty Mental Health Services and Substance Use Disorder Services
5.5.3 Non-specialty Mental Health Services Providers
5.5.4 Emergency Mental Health and Substance Use Disorder Services
5.5.5 Mental Health and Substance Use Disorder Services Disputes
5.5.6 No Wrong Door for Mental Health Services

5.5 Mental Health and Substance Use Disorder Benefits

5.5.1 Mental Health Parity Requirements

Contractor must comply with all mental health parity requirements in 42 Code of Federal Regulations (CFR) section 438.900 *et seq*. Contractor must ensure it is not applying any financial or treatment limitation to mental health or Substance Use Disorder (SUD) benefits in any classification that is more restrictive than the predominant financial or treatment limitation applied to medical and surgical benefits in the same classification.

5.5.2 Non-specialty Mental Health Services and Substance Use Disorder Services

A. Non-specialty Mental Health Services (NSMHS) set forth in Welfare and Institutions Code (W&I) section 14189 are Covered Services in accordance with W&I section 14184.402, unless otherwise specifically excluded under the terms of this Contract. Contractor must consider equity in the provision of such services.

B. Contractor must cover NSMHS including: individual and group mental health evaluation and treatment, including psychotherapy, Family Therapy, and Dyadic Services; psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition; outpatient services for the purposes of monitoring drug therapy; psychiatric consultation; and outpatient laboratory, drugs, supplies, and supplements. Contractor must cover hypnotherapy, health behavior assessments and interventions, psychiatric collaborative care, and other NSMHS services described in the Medi-Cal Provider Manual as mental health evaluation and treatment NSMHS. Contractor must cover mental health screening services described in the Medi-Cal Provider Manual as NSMHS, including but not limited to adverse childhood experiences (ACE) screening, brief emotional/behavioral assessments, depression screening, general developmental screening, autism spectrum disorder screening, and other screening services in accordance with Exhibit A, Attachment III, Subsection 5.5.2.F. (*Non-specialty Mental Health Services and Substance Use Disorder Services*). Contractor must cover SUD services including: drug and alcohol Screening, Brief Intervention and Referral to Treatment (SBIRT) services; tobacco cessation counseling; medications for addiction treatment (also known as medication-assisted treatment or MAT) when delivered in Primary Care offices, emergency departments, inpatient hospitals, and other contracted medical settings; and Medically Necessary Behavioral Health Services. Covered NSMHS and SUD Services can be

delivered in person and via Telehealth/telephone as specified in Exhibit A, Attachment III, Subsection 5.3.1 (*Covered Services*).

C. If a Member is receiving NSMHS and is determined to meet the criteria for Specialty Mental Health Services (SMHS) as defined by W&I section 14184.402, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-specialty Mental Health Services and Substance Use Disorder Services*) as required when Members who have established relationships with contracted mental health Providers experience a change in condition requiring SMHS. Likewise, if a Member is receiving SMHS and is determined to meet the criteria for NSMHS as defined by W&I section 14184.402, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-specialty Mental Health Services and Substance Use Disorder Services*) as required when Members who have established relationships with SMHS Providers experience a change in condition requiring NSMHS. Contractor must continue to cover the provision of NSMHS provided to a Member concurrently receiving SMHS when those services are not duplicative and provide coordination of care with the County Mental Health Plan (MHP) in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-specialty Mental Health Services and Substance Use Disorder Services*). This provision does not preclude coverage of Behavioral Health Services that are within the scope of practice of licensed mental health care Primary Care Providers (PCPs) and mental health care Providers in accordance with All Plan Letter (APL) 22-006 and APL15-008.

D. For Members ages 21 and over who meet the criteria for NSMHS set forth in the W&I section 14184.402(b)(2), Contractor must cover NSMHS that are Medically Necessary Covered Services in accordance with W&I section 14059.5. For Members ages 21 and over, Contractor must cover SUD services that are Medically Necessary Covered Services in accordance with W&I section 14059.5. Contractor's coverage of NSMHS and SUD services must comply with W&I section 14184.402(f).

E. For Members less than 21 years of age, Contractor must cover NSMHS that are Medically Necessary Covered Services in accordance with W&I section 14184.402(b)(2). For Members less than 21 years of age, Contractor must cover SUD services that are Medically Necessary Covered Services. Medical Necessity determinations for NSMHS and SUD services must be made pursuant to W&I section 14059.5, and as required pursuant to 42 United States Code (USC) section 1396dI. For Members less than 21 years of age, NSMHS and Covered SUD services

are Medically Necessary if they are necessary to correct or ameliorate a mental health or substance use condition discovered by an Early Periodic Screening, Diagnosis and Testing (EPSDT) screening. NSMHS and SUD services need not be curative or restorative to ameliorate a mental health or substance use condition. NSMHS and SUD services that sustain, support, improve, or make more tolerable a mental health or substance use condition are considered to ameliorate the mental health or substance use condition, and Contractor must cover them. Contractor's coverage of NSMHS and SUD services must comply with W&I section 14184.402(f).

F. Contractor must cover mental health and SUD screening, including, but not limited to, tobacco, alcohol and illicit drug screening, in accordance with American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule and United States Preventive Services Taskforce (USPSTF) grade A and B recommendations for adults; ACE screening; brief emotional/behavioral assessments; depression screening; general developmental screening; autism spectrum disorder screening; and SBIRT Services. Contractor must develop and implement policies and procedures for mental health and substance use screenings and services provided by a PCP, including, but not limited to, provision of SBIRT Services, and referrals for additional assessments and treatments as indicated by the discovery of condition or potential conditions from screening services, as required by Exhibit A, Attachment III, Subsections 4.3.12 (*Mental Health Services*) and 4.3.13 (*Alcohol and Substance Use Disorder Treatment Services*).

G. Contractor must cover a mental health assessment without requiring Prior Authorization. Contractor must follow the authorization criteria requirements outlined in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*) of this Contract for authorizing additional mental health and SUD services. Consistent with the No Wrong Door policies set forth in W&I section 14184.402, Contractor must cover the assessment and any NSMHS provided during the assessment period for any Member seeking care, even prior to the determination of a diagnosis, even prior to the determination of whether NSMHS criteria set forth in W&I section 14184.402(b)(2) are met, and even if the Member is later determined to need SMHS and/or SUD services and is referred to the MHP or to the County Department responsible for SUD treatment. Contractor must cover NSMHS even if the service was not included in the individual treatment plan, and even if the Member has a co-occurring mental health condition and SUD.

H. Contractor must develop and implement policies and procedures for tracking mental and Behavioral Health screenings, assessments, and treatment services provided by licensed mental health care Providers.

I. Contractor must cover and pay for all mental health and SUD services that are Medically Necessary Covered Services for the Member, including the following:

1) Emergency room professional services as described in 22 CCR section 53855 including all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an Emergency Medical Condition and, if an Emergency Medical Condition exists, for all services Medically Necessary to stabilize the Member;

2) Facility charges claimed by emergency departments per APL 22-005 and Behavioral Health Information Notice (BHIN) 22-011;

3) All laboratory and radiology services necessary for the diagnosis, monitoring, or treatment of a Member's mental health condition;

4) Non-Medical Transportation (NMT) services required by Members to access Medi-Cal covered mental health services and SUD services, in compliance with APL 22-008 and this Contract. These services include, but are not limited to, SMHS, Drug Medi-Cal (DMC) services, and Drug Medi-Cal Organized Delivery System (DMC-ODS) services;

5) NMT services and, for Members less than 21 years of age, Non-Emergency Medical Transportation (NEMT) services, to and from DMC services, DMC-ODS services, and SMHS, in compliance with APL 22-008 and this Contract;

6) Medically Necessary Covered Services after Contractor has been notified by a DMC, DMC-ODS, County Mental Health Plan (MHP), or mental health Provider that a Member has been admitted to an inpatient psychiatric facility, including an Institution for Mental Diseases (IMD) as defined by 9 CCR section 1810.222.1, regardless of the age of the Member. These services include, but are not limited to:

a) The initial health history and physical examination required upon admission, consultations, and any Medically Necessary

Back to Agenda Back to Item

Covered Services; Skilled Nursing Facility (SNF) room and board when psychiatric nursing facility services are provided to Members age 65 and over.

b) Contractor must not cover other inpatient psychiatric facility room and board charges or other services that are reimbursed as part of the inpatient psychiatric facility per diem rate.

7) All Medically Necessary Medi-Cal covered psychotherapeutic drugs, when administered in the outpatient setting as part of medical services for Members not otherwise excluded under this Contract. This includes reimbursement for Medically Necessary Medi-Cal covered psychotherapeutic drugs administered by out-of-Network Providers for Members not otherwise excluded under this Contract;

8) Reimbursement to pharmacies for psychotherapeutic drugs must be provided through the Medi-Cal Fee-For-Service (FFS) program. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal Provider in the Medi-Cal FFS program;

9) Contractor must not materially delay access to Covered Services per Paragraphs 3), 4), and 5) above through the application of Utilization Review controls, such as Prior Authorization, or by requiring that Covered Services be provided through Contractor's Network, consistent with Contractor's obligation to provide timely Covered Services under this contract.

J. Contractor must use DHCS-approved standardized screening tools (including standardized screening tools specific for adults and standardized screening tools specific for Children and youth) to ensure Members seeking mental health services who are not currently receiving covered NSMHS or SMHS are referred to the appropriate delivery system for mental health services, either in Contractor's Network or the MHP's network, in accordance with the No Wrong Door policies set forth in W&I section 14184.402(h) and specified in Exhibit A, Attachment III, Subsection 4.3.12 (*Mental Health Services*).

K. If a Member becomes eligible for SMHS while receiving covered NSMHS, Contractor must continue the provision of non-duplicative, Medically Necessary NSMHS even if the Member is simultaneously accessing SMHS.

Back to Agenda Back to Item

1) Contractor must enter into a MOU with the MHP in accordance with Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to ensure Medically Necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative.

2) Contractor must develop and implement written policies and procedures to ensure that Members meeting criteria for SMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred to the MHP in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*). Likewise, Contractor must develop and implement written policies and procedures to ensure that Members meeting criteria for NSMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred by the MHP to Contractor in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*).

L. Contractor must make best efforts to ensure that a Member's existing mental health Provider is notified during an Urgent Care situation, when possible. Contractor must allow the Member's existing mental health Provider to coordinate care with the MHP or emergency room personnel for Urgent Care.

M. Contractor must develop and implement policies and procedures for the provision of psychiatric emergencies during non-business hours.

N. Contractor must monitor and track utilization data for NSMHS as specified in Exhibit A, Attachment III, Subsection 2.3.3 (*Review of Utilization Data*).

5.5.3 Non-specialty Mental Health Services Providers

A. In addition to Exhibit A, Attachment III, Subsection 5.2.1 (*Access to Network Providers and Covered Services*), Contractor must increase the number of NSMHS Providers within its Network as necessary to accommodate anticipated Enrollment growth, which DHCS will evaluate through the Network certification. Contractor may contract with any mental health care Provider to provide services within their scope of practice. The number of NSMHS Providers available must be sufficient to meet referral and appointment access standards for routine care and must meet the Timely Access Regulation per Health and Safety Code (H&S) section

1367.03, and 28 CCR section 1300.67.2.2, in accordance with the requirements set forth in Exhibit A, Attachment III, Subsection 5.2.3.D (*Network Composition*). Contractor's NSMHS Providers must support current and desired service utilization trends for its Members.

1) Contractor must authorize and arrange for out-of-Network Providers when the provider type is unavailable within time or distance standards. Authorization of out-of-Network Providers in Contractor's Service Area(s) must be prioritized over authorization of out-of-Network Providers in adjoining Service Area(s), unless an out-of-Network Provider in an adjoining Service Area(s) is more conveniently located for a Member or meets time or distance standards.

2) Contractor may contract with a MHP to ensure access to NSMHS.

   Contractor must develop and implement policies and procedures for the secure exchange of Member Information with the MHP to facilitate referrals and Care Coordination. The policies and procedures must cover:

   a) Sharing Protected Health Information (PHI) with the MHP for SMHS and the County Department responsible for SUD treatment, including when required by law, obtaining Member authorization to release information that allows the exchange of treatment history, active treatment, and health information;

   b) Data sharing agreements with the MHP for SMHS and the County Department responsible for SUD treatment and, when required by law, a Business Associate Agreement that addresses the sharing of information related to mental health services and SBIRT services; and

   c) Collecting and reporting data on Members receiving Medi-Cal NSMHS to the MHP.

B. Notwithstanding Exhibit A, Attachment III, Subsection 2.2.13 (*Credentialing and Recredentialing*), if a NSMHS Provider is accredited by the National Committee for Quality Assurance (NCQA), Contractor may deem the Provider credentialed or re-credentialed. Additionally, Contractor must develop and maintain policies and procedures that ensure that the credentials of licensed NSMHS Providers have been verified in accordance with 42 CFR section 438.214 and APL 22-013.

Back to Agenda Back to Item

C. Any time that a Member requires a Medically Necessary NSMHS that is not available within the Network, Contractor must ensure timely access to out-of-Network Providers and Telehealth Providers, in accordance with H&S section 1367.03 and 28 CCR section 1300.67.2, as necessary to meet NSMHS access requirements.

5.5.4 Emergency Mental Health and Substance Use Disorder Services

In addition to the requirements set forth in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*), Contractor must have a MOU with the MHP to refer Members in need of Urgent Care and Emergency Services, including person-to-person telephone transfers, to the county crisis program during their call center hours. The MOU must be executed in accordance with the requirements specified in Exhibit A, Attachment III, Sections 4.3 (*Population Health Management and Coordination of Care*) and 5.3 (*Scope of Services*).

5.5.5 Mental Health and Substance Use Disorder Services Disputes

If Contractor and an MHP cannot agree on the appropriate place of care, disputes must be resolved pursuant to APL 21-013.

A. Contractor must enter an MOU with the MHP in accordance with Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) to include a process for resolving disputes between Contractor and the MHP that includes a means for Members to receive Medically Necessary services, including NSMHS, while the dispute is being resolved.

B. Pursuant to 9 CCR section 1850.525, Contractor must not delay the provision of Medically Necessary services during the resolution of a dispute between Contractor and MHP. Contractor must comply with the rules set forth in 9 CCR section 1850.525 for determining the responsibility for managing ongoing care and financial responsibility for services provided to Members during the dispute period. When disputes concern Contractor's contention that the MHP is required to deliver SMHS to a Member either because the Member's condition would not be responsive to physical health care based treatment or because the MHP has incorrectly determined that the Member's does not meet SMHS criteria, Contractor must manage the care of the Member in accordance with 9 CCR section 1850.525 and APL 21-013 until the dispute is resolved.

C. Contractor must provide case management and Care Coordination for all Medically Necessary services, including those services that are the subject of a dispute between Contractor and an MHP.

D. Regardless of MOU status, Contractor and the MHP must adhere to the routine dispute resolution process and expedited dispute resolution process requirements set forth in APL 21-013.

E. If DHCS renders a decision for the dispute that includes a finding that Contractor is financially liable to the MHP for services, Contractor must comply with the requirements in 9 CCR section 1850.530. If necessary, DHCS will enforce the decision, including withholding funds to meet any financial liability.

F. Contractor must monitor and track the number of disputes with MHPs. Upon request, Contractor must report all disputes to DHCS.

5.5.6 No Wrong Door for Mental Health Services

Contractor must implement policy to ensure that Members receive timely mental health services without delay regardless of the delivery system where they seek care, and are able to maintain treatment relationships with trusted Providers without interruption.

A. Contractor must provide or arrange for the provision of the following NSMHS:

1) Mental health evaluation and treatment, including individual, group, and family psychotherapy.

2) Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.

3) Outpatient services for purposes of monitoring drug therapy.

4) Psychiatric consultation, excluding separately billable psychiatric drugs claimed by outpatient pharmacy Providers via Medi-Cal Rx.

5) Outpatient laboratory, drugs, supplies, and supplements.

B. Contractor must provide or arrange for the provision of the NSMHS listed above for the following populations after screening:

1) Members ages 21 and over with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders;

2) Members who are less than 21 years of age, to the extent that they are eligible for services through the EPSDT benefit as described in Exhibit A, Attachment III, Subsection 5.3.4.E (*EPSDT Services*) of this Contract, regardless of the level of distress or impairment, or the presence of a diagnosis; and,

3) Members of any age with potential mental health disorders not yet diagnosed.

C. Contractor must cover and pay for emergency room professional services as described in 22 CCR Section 53855.

D. In accordance with APL 21-014, Contractor must, in a Primary Care setting, provide covered SUD services, including alcohol and drug screening, assessments, brief interventions, and referral to treatment for Members aged 11 years old and older, including Members who are pregnant. Contractor must also provide or arrange for the provision of:

1) Medications for Addiction Treatment (MAT), also known as medication-assisted treatment, provided in Primary Care, inpatient hospital, emergency departments, and other contracted medical settings; and

2) Emergency Services necessary to stabilize the Member.

E. Contractor must implement standardized Screening and Transition of Care Tools for Medi-Cal Mental Health Services in accordance with APL 22-005 and APL 22-028. Contractor must update and align policies and procedures and MOUs with mental health plans to ensure compliance and communicate updates to Providers as necessary.

1) In accordance with APL 22-005, Members ages 21 and over must be screened using the Adult Screening Tool and transitioned using the Adult Transition of Care Tool.

2) In accordance with APL 22-005, Members less than 21 years of age must be screened using the Youth Screening Tool and transitioned using the Youth Transition of Care Tool.

F. Consistent with W&I section 14184.402(f) and APL 22-005, Contractor must cover clinically appropriate and covered NSMHS prevention, screening, assessment, and treatment services even when:

Back to Agenda Back to Item

1) Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;

2) Services are not included in an individual treatment plan;

3) The Member has a co-occurring mental health condition and SUD; or

4) NSMHS and SMHS are provided concurrently, if those services are coordinated and not duplicated.

Exhibit A, ATTACHMENT III

5.6 MOUs with Local Government Agencies, County Programs, and Third Parties

5.6.1 MOU Purpose
5.6.2 MOU Requirements
5.6.3 MOU Oversight and Compliance

5.6 MOUs with Local Government Agencies, County Programs, and Third Parties

Memorandum of Understandings (MOUs) entered into pursuant to this Contract and as set forth in All Plan Letters (APLs) are binding, contractual agreements between Contractor and third parties that set forth the responsibilities and obligations of Contractor and a third party, including Local Government Agencies, county programs, and third-party entities, to coordinate and facilitate the provision of Medically Necessary services to Members, sharing data, and as applicable, avoiding the duplication of services where Members are served by multiple parties.

5.6.1 MOU Purpose

Contractor must coordinate with Local Government Agencies (LGAs), county programs, and third-party entities to ensure that Members receive all Medically Necessary services even if those services are not the financial responsibility of Contractor. In circumstances where Contractor is coordinating care and not financially responsible for the care, Contractor must negotiate in good faith and execute a MOU, incorporating all required provisions of this Contract, APLs, and MOU templates and guidance, with the following Local Government Agencies, county program and third-party entities and county programs to ensure Care Coordination, data sharing, and non-duplicative services for Members. Contractor and the LGAs, county programs, and third-party entities may incorporate requirements in addition to any requirements set forth in this Contract or any DHCS issued templates so long as such requirements do not conflict with any required provision. Contractor must use good-faith efforts to consult with persons who have direct experience with Members receiving services from the below programs in the development of the MOU.

A. Contractor must execute MOUs with Local Health Departments (LHDs) in each county within Contractor's Service Area for the following programs and services, at a minimum:

1) California Children's Services (CCS);

2) Maternal and Child Health (MCH);

3) Tuberculosis (TB) Direct Observed Therapy (DOT);

4) For Community Health Worker (CHW) services, as appropriate; and

5) All other Medically Necessary services that are the responsibility of LHDs, not otherwise specified.

B. Contractor must execute MOUs with Women, Infants, & Children (WIC) agencies in each county within Contractor's Service Area.

C. Contractor must execute MOUs with LGAs, such as the County Behavioral Health Department and County Social Services Department, in each county within Contractor's Service Area to assist with coordinating the following programs and services, at a minimum:

1) Specialty Mental Health Services (SMHS);

2) Alcohol and Substance Use Disorder (SUD) treatment services including counties participating in the Drug Medi-Cal Organized Delivery System (DMC-ODS); 3) In-Home Supportive Services (IHSS).

D. Contractor must execute MOUs to coordinate programs and services for Members with the following LGAs in each county within Contractor's Service Area, at a minimum:

1) Social services; and

2) Child welfare departments.

E. Contractor must execute MOUs to coordinate services provided by Regional Centers (RCs) for persons with Developmental Disabilities in accordance with APLs relevant to MOUs, including DHCS issued templates.

F. By July 1, 2024 (or such later date determined by DHCS), Contractor must execute MOUs with LGAs in each county within Contractor's Service Area to assist with coordinating, at a minimum, Targeted Case Management (TCM).

G. By January 1, 2025 (or such later date determined by DHCS):

1) Contractor must collaborate with and execute MOUs with Local Education Agencies (LEAs) in each county within Contractor's Service Area to ensure that Members' Primary Care Provider (PCP) cooperates and collaborates in the development of Individual Education Plans (IEP) or Individual Family Service Plans (IFSP) as

Back to Agenda Back to Item

required in Exhibit A, Attachment III, Subsection 4.3.16 (*School-Based Services*).

2) Contractor must collaborate and execute MOUs, with California Department of Corrections and Rehabilitation, county jails, and youth correctional facilities.

H. Contractor must execute MOUs to coordinate programs and services for Members with the following third-party entities in each county within Contractor's Service Area, at a minimum:

1) Home and Community-Based Services (HCBS) program agencies;

2) Continuum of care programs;

3) First 5 county commissions.~~;~~

5.6.2 MOU Requirements

A. MOUs must contain all the following components, at a minimum:

1) Identification of services that are the responsibilities of each party under the MOU and the populations that are to be served;

2) Identification of the oversight responsibilities of each party, including the designation of a responsible person and liaison by each party, and notification to the other party of changes to the responsible person and liaison;

3) Establishment of policies and procedures for eligibility, screening, assessment, evaluation, Medical Necessity determination, and referral systems;

4) Establishment of policies and procedures for coordinating Member care between the parties, including but not limited to, referrals to applicable Enhanced Care Management (ECM), Community Supports and/or community-based resources;

5) Establishment of policies and procedures for the timely and frequent exchange of Member Information and data, including Behavioral Health and physical health data, maintaining the confidentiality of exchanged information and data, and obtaining Member consent;

Back to Agenda Back to Item

6) Establishment of policies and procedures to address and document Quality Improvement (QI) activities for services covered under the MOU, including but not limited to, any applicable performance measures and QI initiatives, reports that track cross-system referrals, Member engagement, and service utilization;

7) Contractor must post on its website the date and time ~~of~~ the quarterly meeting occurred, and, as applicable, distribute to meeting participants a summary of any follow-up action items, changes to processes, or Corrective Actions that are necessary to fulfill obligations under this Contract and MOU.

8) Contractor must invite other party's executives to participate in quarterly meetings to facilitate appropriate committee representation, including local presence, to discuss and address Care Coordination and MOU-related issues.

9) Agreement by both parties, to the extent such non-Contractor party will agree to participate in quarterly meetings to discuss Care Coordination as well as systemic and case-specific concerns including allowing Subcontractors and Downstream Subcontractors to participate, as appropriate;

10) Establishment of policies and procedures detailing how complaints can be raised and how to resolve disputes between the parties, including but not limited to, a mutually agreed upon review process to facilitate timely resolution of disputes, differences of opinion and responsible entity for covering services until the dispute is resolved. The review process must not result in delays in Member access to services pending formal dispute resolution;

11) Establishment of policies and procedures regarding Member access to Medically Necessary services and Network Providers during non-business hours;

12) Policies and procedures for Member, Subcontractor, Downstream Subcontractor, and Network Provider education related to access to services covered under the MOU; and

13) Establishment of policies and procedures to address emergency preparedness protocols in accordance with Exhibit A, Attachment III, Article 6.0 (*Emergency Preparedness and Response*).

B. In addition to the MOU requirements listed in Paragraph A of this Subsection, MOUs must contain the following components identified in this Paragraph B, as applicable:

1) MOUs with County Mental Health Plans (MHPs)

a) The requirements contained in Welfare and Institutions Code (W&I) section 14715;

b) Policies and procedures for the delivery of SMHS, including the MHP's provision of clinical consultation with Contractor for Members being treated for mental illness;

c) Policies and procedures for the delivery of Medically Necessary Non-specialty Mental Health Services (NSMHS) within the PCP's scope of practice;

d) Policies and procedures for the timely and frequent exchange of Member information and data, including, as applicable, Behavioral Health and physical health data, maintaining the confidentiality of exchanged information and data, and, if necessary, obtaining Member consent;

e) Policies and procedures for the delivery of Medically Necessary Covered Services to Members who require SMHS, including but not limited to:

i. Prescription Drugs when administered in an outpatient setting and not otherwise excluded under this Contract;

ii. Laboratory, radiological and radioisotope services;

iii. Emergency room facility charges and professional services;

iv. Transportation;

v. Home health services;

vi. Drug Medi-Cal; and

Back to Agenda Back to Item

vii. Medically Necessary Covered Services for Members who are patients in psychiatric inpatient hospitals or IMDs.

f) A provision that states any decision rendered by DHCS regarding a dispute between Contractor and the MHP concerning provision of Covered Services is not subject to the dispute procedures specified in Exhibit E, Section 1.21 (*Contractor's Dispute Resolution Requirements*);

g) Policies and procedures to ensure Medically Necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative; and

h) Policies and procedures to ensure that Members meeting criteria for SMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred to the MHP in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*) and Exhibit A, Attachment III, Subsection 5.5.2 (*Non-specialty Mental Health Services and Substance Use Disorder Services*). Likewise, policies and procedures to ensure that Members meeting criteria for NSMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred by the MHP to Contractor in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*) and Exhibit A, Attachment III, Subsection 5.5.2 (*Non-specialty Mental Health Services and Substance Use Disorder Services*).

i) Contractor must report to DHCS updates from quarterly meetings in a manner and frequency specified by DHCS.

C. If Contractor reimburses the third-party entities or LGAs listed in Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) for services rendered, Contractor must execute a Network Provider Agreement, Subcontractor Agreement, and/or Downstream Subcontractor Agreement, as appropriate, in accordance with Exhibit A, Attachment III, Section 3.1 (*Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties*).

Back to Agenda Back to Item

D. Executed MOUs must be publicly posted.

E. MOUs must not be delegated, except that Contractor may delegate its obligations under the MOU to a Fully Delegated Subcontractor or Partially Delegated Subcontractor, provided that such Fully Delegated Subcontractor or Partially Delegated Subcontractor is made a party to the MOU.

5.6.3 MOU Oversight and Compliance

A. MOU Oversight Requirements

Contractor must have processes in place to maintain collaboration among the parties to the MOU and identify strategies to monitor and assess the effectiveness of MOUs as follows:

1) Conduct regular meetings, which include the designated individuals responsible for oversight and performance under the MOU, at least quarterly to address policy and practical concerns that may arise between MOU parties;

2) Resolve conflicts between MOU parties within a reasonable timeframe;

3) Designate a contact person to be responsible for the oversight and supervision of the terms of any MOUs and notify DHCS within five Working Days of any change to Contractor's liaison or responsible person as listed in the MOU;

4) Ensure Subcontractors, Downstream Subcontractors, and Network Providers comply with any applicable provisions of the MOU;

5) Provide education and training of MOU as required by Exhibit A, Attachment III, Subsection 5.6.2.A.12) above;

6) If DHCS requests a review of any existing MOU, Contractor must submit the requested MOU within ten Working Days of receipt of the request;

7) Ensure appropriate committee representation by inviting a local presence in advance to each quarterly meeting an opportunity to discuss and address Care Coordination and MOU-related issues with county executives;

8) Ensure an appropriate level of leadership are invited to participate in MOU engagements from both Contractor and entity as appropriate; and

9) Report to DHCS updates from quarterly meetings in a manner and frequency specified by DHCS through APLs and guidance.

B. MOU Compliance Requirements

1) At a minimum, executed MOUs listed in this Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) must be submitted to DHCS.

2) To the extent Contractor does not execute MOU within the timeframe required under this Contract and relevant APLs, Contractor must submit quarterly reports to DHCS documenting its continuing good faith efforts to execute the MOU, until such time as the MOU is executed. Documentation of good faith efforts must include a description of attempts made to execute an MOU and the explanation for why the MOU has not been executed.

3) Contractor, at a minimum, must review its MOUs annually for any needed modifications or renewal of responsibilities and obligations outlined within. Contractor must submit to DHCS' Contract Manager evidence of the annual review of MOUs as well as copies of any MOUs modified or renewed as a result.

4) Contractor must report on its compliance with the MOU to Contractor's compliance officer at least on a quarterly basis.

Back to Agenda Back to Item

Exhibit A, ATTACHMENT III

6.0 Emergency Preparedness and Response (To Become Effective on January 1, 2025)

This Article's provisions, which will become effective on January 1, 2025, make explicit DHCS' commitment to ensuring that the Medi-Cal managed care delivery system is prepared for those unforeseen circumstances that require immediate action. Specifically, Contractors must plan for and ensure continuity of business operations, delivery of essential care and services to Members, and mitigate potential harm caused by Emergencies, such as a natural or manmade disaster or public health crisis. This Article includes provisions requiring that Contractor must maintain an Emergency Preparedness and Response Plan, including a Business Continuity Plan and Member Emergency Preparedness Plan. In addition, during a federal, State, or county declared state of Emergency, Contractor must implement protocols that allow Members timely access to Covered Services including by allowing flexibility for Prior Authorization, pre-certification, and referrals.

6.1 Emergency Preparedness and Response (To Become Effective on January 1, 2025)

6.1.1 General Requirements
6.1.2 Business Continuity Emergency Plan
6.1.3 Member Emergency Preparedness Plan
6.1.4 California's Standardized Emergency Management System
6.1.5 Reporting Requirements During an Emergency
6.1.6 DHCS Emergency Directives

Back to Agenda Back to Item

6.1 Emergency Preparedness and Response

6.1.1 General Requirements

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), "Emergency" means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by public health crises, natural and man-made hazards, or disasters.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), "Emergency Preparedness" means a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking Corrective Action in an effort to ensure effective coordination during incident response. Contractor's Emergency Preparedness process is one element of a broader national preparedness system to prevent, respond to, and recover from public health crises, natural disasters, acts of terrorism, and other disasters.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), "Emergency Preparedness and Response Plan" means an Emergency plan put in place by Contractor to ensure continuity of its business operations, to ensure delivery of essential care and services to Members, and to help mitigate potential harm caused by an Emergency.

This Article 6.0 (*Emergency Preparedness and Response*) will not become effective until January 1, 2025. Contractor must immediately comply with all requirements in this Contract relating to this Article 6.0 (*Emergency Preparedness and Response*) set out in Exhibit A, Attachment II, Article 1.0 (*Operational Readiness Deliverables and Requirements*) upon becoming effective January 1, 2025. Nothing in this Article 6.0 (*Emergency Preparedness and Response*) is intended to relieve Contractor of any other duties or requirements that would otherwise apply, such as any duties or requirements under federal and State laws and regulations relating to Emergency Preparedness.

Contractor must have in place an Emergency Preparedness and Response Plan which includes, at a minimum

A. A Business Continuity Emergency Plan, as described in Exhibit A, Attachment III, Section 6.2 *(Business Continuity Emergency Plan*)*;*

B. A Member Emergency Preparedness Plan, as described in Exhibit A, Attachment III, Section 6.3 *(Member Emergency Preparedness Plan*)*;* and

Back to Agenda Back to Item

C. Contractor's policies and procedures for complying with all of the requirements set forth in this Article 6.0 (*Emergency Preparedness and Response*).

Contractor must submit its Emergency Preparedness and Response Plan to DHCS for approval prior to the start of Contractor's operations. Contractor mustsubmit any updates to deliverables identified in this Section to DHCS as requested.

6.1.2 Business Continuity Emergency Plan

Contractor must have a Business Continuity Emergency Plan in place to deal with any Emergency that may affect Contractor's business operations, including, but not limited to, access to Network Providers, Subcontractors, and Downstream Subcontractors; communications; staffing; supplies; and information technology concerns.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), a "Business Continuity Emergency Plan" means a document consisting of the critical information and processes Contractor needs to continue operating during an Emergency.

Contractor must consider the availability of local resources and requirements and, upon request, coordinate with local city and county Emergency Preparedness programs when establishing its Business Continuity Emergency Plan.

At a minimum, Contractor's Business Continuity Emergency Plan must address the following:

A. Communication

Contractor must describe how it will communicate with staff, Network Providers, Subcontractors, Downstream Subcontractors, DHCS, and other essential persons and entities during an Emergency. Contractor must also include how Contractor will provide Member, Network Provider, Subcontractor, and Downstream Subcontractor access to call centers for questions; how Contractor will provide dedicated staff and resources toward the Emergency process; and how Contractor will address the continual and timely resolution of claims. Contractor must maintain Emergency contact information, telephone numbers, and other contact

Back to Agenda Back to Item

information (including contact name, title or position, physical location address, mailing address, telephone and/or cell phone, text, e-mail, and social media) for staff, Network Providers, Subcontractors, Downstream Subcontractors, and other essential persons and entities. Contractor must update this contact information as changes occur, but no less than every six months.

B. Emergency Preparedness Risk Assessment

Contractor must identify and assess potential public health crises and natural or man-made Emergencies, including, but not limited to, epidemics, pandemics, earthquakes, fires, floods, storms, hurricanes, tornados, power outages, gas leaks, bomb threats or presence of explosives, explosions, hazardous materials incidents, relocations or evacuations, assaults, intrusions, bioterrorism, injuries, riots, and information technology security incidents that could arise at any location in which Contractor conducts business operations under this Contract. When assessing the risk of a potential Emergency, Contractor must consider the likelihood of the Emergency within its Service Area and how the Emergency may disrupt Contractor's business operations. Contractor must identify and assess any essential supply chain impacts that may disrupt business operations during or after the Emergency. Contractor must update its assessment as changes occur, but at least on an annual basis.

C. Emergency Team Staffing and Responsibilities

1) Contractor must identify an Emergency team and back-up Emergency team members to carry out Contractor's Business Continuity Emergency Plan in the event of an Emergency.

2) Contractor must clearly designate the Emergency team's responsibilities during an Emergency, including, but not limited to, sending out Emergency communications to Contractor's employees, Network Providers, Subcontractors, Downstream Subcontractors, Members, managing site security staff, those staff responsible for securing utilities, and other essential persons and entities.

3) Contractor must ensure that Emergency team members know how to report their status to the Emergency team during and after an Emergency to keep Contractor informed of changing needs.

D. Cooperative Arrangements

Contractor must attempt to establish cooperative arrangements with other local health care organizations to assist and provide mutual aid during an Emergency when business operations are affected. Contractor must submit to DHCS an attestation that it will update its cooperative arrangements at least annually and submit to DHCS.

E. Training and Drills

1) Contractor must establish an Emergency training program to train new and existing staff on Contractor's Business Continuity Emergency Plan.

2) Contractor must conduct annual Business Continuity Emergency Plan drills to ensure Emergency Preparedness and to detect vulnerabilities that can be addressed before an actual Emergency arises. Contractor must submit a report to DHCS within 30 calendar days of each training drill which identifies drill activities, provides a summary of outcomes, and creates a plan to address any vulnerabilities found.

3) Contractor must, upon request, participate in mock disaster drills coordinated by governmental entities, if available, to ensure coordination during an Emergency.

4) Contractor must ensure that the equipment and supplies necessary to sustain business operations are readily available in the event of an Emergency.

F. Systems Recovery

1) Emergency Operation

Contractor must establish a plan to maintain critical business processes that protects confidential and sensitive electronic and non-electronic information, including, but not limited to, Protected Health Information (PHI), personal information, and claims information during an Emergency.

2) Data Backup

Contractor must establish procedures to backup confidential and sensitive electronic information, including, but not limited to, PHI, PI, and claims information to maintain the ability to retrieve such

Back to Agenda Back to Item

information during an Emergency. Contractor must establish a regular schedule for conducting backup procedures, storing backup information offsite, updating an inventory of backup media, and formulating an estimate for the time needed to restore lost confidential and sensitive information. At a minimum, Contractor must conduct a full backup process of its confidential and sensitive electronic information on a weekly basis and update its offsite data storage on a monthly basis.

6.1.3 Member Emergency Preparedness Plan

Contractor must establish a Member Emergency Preparedness Plan to address its Members' needs during an Emergency, including for Members in Long-Term Care facilities, Skilled Nursing Facilities, or other institutional settings; and for Members with disabilities, limitations in activities of daily living, and/or cognitive impairments.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), a "Member Emergency Preparedness Plan" means a required subsection of the Emergency Preparedness and Response Plan that details the required coordination between Contractor and its Members, Network Providers, Subcontractors, and Downstream Subcontractors to ensure Member access to health care services in the event of an Emergency.

At a minimum, Contractor's Member Emergency Preparedness Plan must address the following:

A. Member Communication

1) Contractor must have the ability to set up a Member services call center for communication with Members before, during, and after an Emergency.

2) Contractor must establish Emergency protocols for its Member services call center. Protocols must include, but are not limited to, call scripts that account for different Member needs, staff training in crisis response, Contractor Emergency protocols that ensure access to Covered Services, and processes for escalating a call through warm hand-off connections to nurses or doctors for Members needing immediate assistance.

3) During and post-Emergency, Contractor must:

a) Instruct Members about how to reach Contractor's nurse advice line, care coordinators, Medi-Cal Rx pharmacy services, Telehealth services, and other Contractor services and resources as deemed appropriate;

b) Notify Members about available alternative primary pharmacy, dialysis center, chemotherapy or other infusion therapy location, and other treatment sites;

c) Inform Members about how Contractor may modify its care protocols and Member benefits to ensure continued access to Medically Necessary services;

d) Provide Members with information on how to obtain medical authorizations, out-of-Network care, medication refills or Emergency supply, Durable Medical Equipment (DME) and replacements, and Medical Records; and

e) Inform Members about how to access behavioral and mental health services.

B. Continuity of Covered Services

1) Contractor must ensure that Members impacted by a federal, State, or county declared state of Emergency continue to have access to Covered Services. Contractor must take actions to ensure continued access, including but not limited to the following:

a) Relaxing time limits for Prior Authorization, pre-certification, and referrals;

b) Extending filing deadlines for Grievances and requests for Appeal in accordance with Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

c) Coordinating, transferring, and referring Members to alternate sources of care when Providers are closed, unable to meet the demands of a medical surge, or otherwise affected by an Emergency;

d) Authorizing Members to replace DME or medical supplies out-of-Network;

e) Allowing Members to access appropriate out-of-Network Providers if Network Providers are unavailable due to an Emergency or if the Member is outside of the Service Area due to displacement; and

f) Providing, when directed, a toll-free telephone number for displaced Members to call with questions, including questions about the loss of a Beneficiary Identification Card, access to prescription refills, and how to access health care.

2) Contractor must establish policies and procedures to immediately implement these actions as necessary or as directed by DHCS.

C. Network Provider, Subcontractor, and Downstream Subcontractor Emergency Requirements

1) Education

a) Contractor must educate Network Providers, as a part of training in accordance with Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training*); Subcontractors; and Downstream Subcontractors on Contractor's Emergency policies and procedures.

b) Contractor must provide Network Providers, Subcontractors, and Downstream Subcontractors with an Emergency Preparedness fact sheet and resources on general Emergency Preparedness, response, and communications protocols.

2) Communications During an Emergency

a) Contractor must have a system and process in place to be able to provide and receive information from Network Providers, Subcontractors, and Downstream Subcontractors during an Emergency.

b) Contractor musthave a process in place to inform Network Providers, Subcontractors, and Downstream Subcontractors about what modifications need to be implemented during an Emergency to ensure that Members are able to access Covered Services, and how Contractor can assist Network Providers, Subcontractors, and Downstream Subcontractors in those efforts.

3) Network Provider Agreements

a) Contractor's Network Provider Agreements must state that Network Providers are required to:

i. Annually submit evidence of adherence to Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Final Rule (FR), 81 FR 63859, and 84 FR 51732;

ii. Advise Contractor as part of the Network Provider's Emergency plan; and

iii. Notify Contractor within 24 hours of an Emergency if the Network Provider closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an Emergency.

6.1.4 California's Standardized Emergency Management System

A. Contractor must cooperate with local city and county Emergency Preparedness programs within Contractor's Service Area to ensure provision of health care services.

B. Contractor must, upon request, educate and prepare staff on the California State Emergency Plan and prepare staff to participate in California's Standardized Emergency Management System (SEMS).

C. Contractor must maintain contact information for local city and county Emergency Preparedness programs within Contractor's Service Area.

D. Contractor must ensure that its medical director and Grievance and Appeals coordinator are able to receive communications from the California Health Alert Network and the California State Warning Center.

6.1.5 Reporting Requirements During an Emergency

A. Within 24 hours of a federal, State, or county declared state of Emergency located within Contractor's Service Area, Contractor must notify DHCS as to whether Contractor has experienced or expects to experience any disruption to its operations.

B. At a minimum, Contractor must report the status of its operations once a day to DHCS, or as directed by DHCS.

C. Contractor's daily report to DHCS must include, at a minimum, the following information:

1) The number of Members in Contractor's Service Area affected by the Emergency, per county, including the number of medium-to-high health risk Members, as identified through the Population Needs Assessment;

2) Information, to the extent available, relating to Network Provider site closures, including:

a) The number of Network Provider site closures by Provider type, per county;

b) The number of Members served by each closed Network Provider, per county;

c) The number of hospitalized Members who need to be transferred;

d) The location(s) of where Members were transferred; and

e) For each closed Network Provider, a list of the alternative Providers or facilities where Members can receive care.

3) The number of Contractor offices that are closed;

4) How Contractor is communicating with impacted Members, Network Providers, Subcontractors, and Downstream Subcontractors;

5) The actions Contractor has taken or will take to meet the continued health care needs of its Members; and

6) The Network Provider, Subcontractor, Downstream Subcontractor, or Member issues Contractor has received.

D. Contractor must comply with any guidance from the California Health and Human Services Agency regarding reporting on the status of Contractor's operations during an Emergency.

6.1.6 DHCS Emergency Directives

When a federal, State, or county Emergency is declared, Contractor agrees that DHCS may, in its sole discretion, waive existing contractual requirements and institute new contractual requirements to address an Emergency pursuant to an Emergency directive. DHCS Emergency directives do not require an amendment to this Contract prior to implementation. Emergency directives to Contractor may be communicated through All Plan Letters, advisory memos, or other similar announcements and are effective when published. Unless otherwise stated, Emergency directives will remain in effect until the Emergency directive is terminated. Contractor must promptly comply with all DHCS Emergency directives.

Exhibit A, Attachment III

7.0 Operations Deliverables and Requirements

To demonstrate the requisite capabilities necessary to execute the obligations of this Contract, DHCS outlines specific deliverables that Contractor must submit to DHCS prior to the implementation of the Contract. This period is considered the Implementation Period at which time DHCS will assess the Medi-Cal managed care plan's readiness to begin operations as a Contractor. These deliverables are identified and set forth in Exhibit A, Attachment II, Section 1.0 (*Operational Readiness Deliverables and Requirements*) of the Contract and the tables that follow that Section.

This Article provides a non-exhaustive list of deliverables required to be submitted by Contractor to the DHCS and/or other entity(ies) throughout the term of the Contract to verify Contractor's continued compliance with Contract requirements. Contractor must submit all required deliverables to DHCS in a complete, accurate, and timely fashion. Contractor must submit all required deliverables to DHCS in an ADA-compliant format if identified in the tables below this section as publicly available. Contractor may be responsible for additional deliverable requirements based on changes in State and federal law and/or DHCS program needs. Contractor must meet any additional requirements, not listed in the tables below, upon DHCS' request and in the form and manner specified by DHCS. Contractor must use the calendar year to define annual, monthly, and quarterly submission timeframes unless directed otherwise.

In the event Contractor fails to submit any deliverables in accordance with the milestones and timeframes required by DHCS, DHCS may impose Sanctions and Liquidated Damages in accordance with Exhibit E, Section 1.19 (*Sanctions*) and Section 1.20 (*Liquidated Damages*) to Contractor.

EXHIBIT A, ATTACHMENT I – 1.0 DEFINITIONS

No deliverables or requirements listed for this Article.

EXHIBIT A, ATTACHMENT I – 2.0 ACRONYMS

No deliverables or requirements listed for this Article.

EXHIBIT A, ATTACHMENT II – 1.0 OPERATIONAL READINESS DELIVERABLES AND REQUIREMENTS

See specific contract Sections below for details.

EXHIBIT A, ATTACHMENT III – 1.1 PLAN ORGANIZATION AND ADMINISTRATION

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0001	Key Personnel Disclosure Form	1.1.2	Annually.		DHCS
D.0114	Medical Director Information	1.1.6	Attest to DHCS that this has been posted no later than January 1 of each year.	Posted in an easily accessible location on Contractor's Provider portal website.	Public
D.0002	Key Personnel Change Notification including CEO, CFO, COO, CMO, Chief Medical Director, Health Equity Officer, Compliance Officer, and Government Relations Person.	1.1.8	Within ten calendar days Within 20 calendar days.	Contractor must post Medical director contact information on their provider portal website.	DHCS; Public

EXHIBIT A, ATTACHMENT III – 1.2 FINANCIAL INFORMATION

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0003	Monthly Financial Reports	1.2.2	Monthly, no later than 30 calendar days after the close of Contractor's fiscal month.	Financial Reports submitted in accordance with this Section 1.2 are public records and may be made public by DHCS.	DHCS
D.0004	Quarterly Financial Reports	1.2.2	Quarterly, no later than 45 calendar days after the close of Contractor's fiscal quarter.		DHCS
D.0005	Annual Financial Reports	1.2.2	Annually, no later than 120 calendar days after the close of Contractor's Fiscal Year.		DHCS
D.0006	Annual Forecasts	1.2.2	Annually, no later than 60 calendar days prior to the beginning of Contractor's next Fiscal Year.		DHCS
D.0007	Independent Financial Audit Report	1.2.3	Annually, no later than 120 calendar days after the close of Contractor's Fiscal Year.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0008	Medical Loss Ratio Report(MLR)	1.2.5; 1.2.5.H	Annually Timeframe and manner determined by DHCS, but no longer than 12 months after the end of the MLR reporting year; and When there is a retroactive change to the Capitation Payments for a MLR reporting year and a new report needs to be submitted to reflect the change.		DHCS
D.0009	Community Reinvestment Plan	1.2.7	Annually.	Posted on Contractor's website.	DHCS
D.0010	Community Reinvestment Report	1.2.7	Annually.	Posted on Contractor's website.	DHCS

EXHIBIT A, ATTACHMENT III – 1.3 PROGRAM INTEGRITY AND COMPLIANCE PROGRAM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0115	Compliance Program	1.3.1.A .9)	Annually.	On Contractor's website.	DHCS
D.0011	Preliminary Fraud, Waste, and Abuse Reports	1.3.2.D .1)	Within ten Working Days of Contractor's discovery of such Fraud, Waste, or Abuse.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0012	Completed Fraud, Waste, and Abuse Investigation Report	1.3.2.D .2)	Within ten Working Days of completing Contractor's Fraud, Waste, or Abuse investigation.		DHCS
D.0013	Quarterly Fraud, Waste, Abuse Status Report	1.3.2.D .3)	Quarterly, ten Working Days after the close of every calendar quarter.		DHCS
D.0014	Suspended, Excluded, or Ineligible Provider Notification	1.3.4.A .6)	Within ten Working Days of removing a suspended, excluded, or ineligible Provider from its Network.		DHCS
D.0116	Disclosures	1.3.5.C	Within 60 calendar days of when it has identified any Capitation Payments or other payments it has received or paid in excess of the amounts specified in this Contract.		
D.0126	Overpayment Notification of $25 million or more	1.3.6.A	Within 60 calendar days of the date the overpayment.		DHCS
D.0131	Overpayment Notification of any amount related to Fraud, Waste, and Abuse	1.3.6.A	Within 10 calendar days of the date the overpayment.		DHCS
D.0106	Overpayment Recoveries Report	1.3.6.B	Annually.		DHCS

EXHIBIT A, ATTACHMENT III – 2.1 MANAGEMENT INFORMATION SYSTEM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0015	Encounter Data Reporting	2.1.2	Within 60 calendar days of the date of adjudication of a claim or receipt of an Encounter as required by this Contract or as otherwise agreed upon by DHCS, or as mandated through federal law; Within six Working Days of the end of each month following the month of payment.		DHCS
D.0017	Network Provider Data Reporting	2.1.4	Within ten calendar days following the end of each month.		DHCS
D.0018	Program Data Reporting	2.1.5	Within ten calendar days following the end of each month.		DHCS
D.0019	Template Data Reporting	2.1.6	On a regular basis, or as mandated through federal law.		DHCS
D.0020	Management Information System/Data Audits	2.1.7	No less frequently than once every three years.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0016	Data Corrective Action Plans	2.1.8	Within 15 calendar days from the date of the DHCS written notice to Contractor regarding any deficiencies and problem related to Contractor's data or its Management and Information System (MIS).	DHCS may publicly disclose on the DHCS website any Contractors that have entered into Corrective Action plans, or that have been subject to sanctions due to non-compliance .	DHCS; public
D.0117	Tracking Member Alternative Format Selections	2.1.9	As Requested by Member in accordance with the requirements in All Plan Letter (APL) 22-002.		DHCS

EXHIBIT A, ATTACHMENT III – 2.2 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0021	Written summary of Quality Improvement and Health Equity Committee (QIHEC) activities, as well as the QIHEC activities of Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors	2.2.3.D	At least quarterly.	On Contractor's website.	DHCS; Public
D.0022	Quality Improvement and Health Equity Plan	2.2.7	Annually.	On Contractor's website.	DHCS; Public
D.0026	NCQA Health Plan Accreditation and Health Equity Accreditation results	2.2.8	After every NCQA accreditation cycle (every 3 years). Within 30 calendar days of the receipt of the completed report from NCQA. Within 15 calendar days of confirmation of the site visit by NCQA.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0024	Health plan Subcontractor and Downstream Subcontractor quality and health equity performance data	2.2.9.A.2	Annually (and as requested by DHCS).		DHCS
D.0023	Performance Improvement Project reporting	2.2.9.B	At intervals determined by DHCS. At least annually.	On the DHCS website.	DHCS; Public
D.0025	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey results and CAHPS results for its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors	2.2.9.C	Annually after January 1, 2026.	On Contractor's website.	DHCS; Public
D.0141	EPSDT/AAP Bright Futures annual attestation for mailing/electronically sharing of DHCS supplied Medi-Cal for Kids and Teens Materials	2.2.10.B.2	Annually, by January 15th.	Yes	Eligible Members under the age of 21. New Members within 7 calendar days of Enrollment

EXHIBIT A, ATTACHMENT III – 2.3 UTILIZATION MANAGEMENT PROGRAM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0027	Appeals Procedure	2.3.1.F	As needed when updated.	On Contractor's website.	DHCS; Public

EXHIBIT A, ATTACHMENT III – 3.1 NETWORK PROVIDER AGREEMENTS, SUBCONTRACTOR AGREEMENTS, DOWNSTREAM SUBCONTRACTOR AGREEMENTS, AND CONTRACTOR'S OVERSIGHT DUTIES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0132	Network Provider Agreement Template	3.1.2.A .1	When updated or when a new provider type		DHCS
D.0133	Subcontractor Agreement Template	3.1.2.B .1.a	When updated or when a new provider type		DHCS
D.0134	Updates to Fully Delegated Subcontractor Agreements Template with Fully Delegated Downstream Subcontractors	3.1.2.B .1.a	As needed when updated		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0135	Updates to Fully Delegated Executed Subcontractor Agreements with Fully Delegated Downstream Subcontractors	3.1.2.B .1.b	As needed when updated		DHCS
D.0028	Delegation Reporting and Compliance Plan	3.1.3; Exh. J	Annually and at any time there is a material change as specified by DHCS within 30 calendar days from either the beginning of the annual reporting period or the material change.	On Contractor's website.	DHCS; Public
D.0029	Non-Federally Qualified HMOs Subcontractor Agreement, Downstream Subcontractor Agreement, and Network Provider Amendment Approval Request	3.1.5	At least 30 calendar days before the effective date, unless otherwise instructed by DHCS Within 60 calendar days after the date the overpayment was identified.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0030	Federally Qualified HMOs Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement	3.1.8	Upon DHCS request.		DHCS
D.0031	Termination Notice of Network Provider Agreement with a Safety-Net Provider	3.1.8	As needed, at least 60 calendar days prior to the effective date of termination or concurrently with the termination if Provider's license has been revoked or suspended or where the health and welfare of a Member is threatened.		DHCS
D.0118	Provider Selection	3.1.10	Upon request.		DHCS
D.0119	Delegation Model	3.1.12		On Contractor's website	

EXHIBIT A, ATTACHMENT III – 3.2 PROVIDER RELATIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0032	Provider Dispute Resolutions Report	3.2.2	Annually.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0033	Most current Provider Manual	3.2.4	As needed. Annually.	Available to the Provider through Provider portals, the Internet or upon request.	Providers
D.0034	Hospital Inpatient Days Report	3.2.8	As required by Welfare and Institutions Code (W&I) section 14105.985(b)(2). Within 30 calendar days of DHCS' request.		DHCS

EXHIBIT A, ATTACHMENT III – 3.3 PROVIDER COMPENSATION ARRANGEMENTS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0035	Alternative and Value-Based Payment Models Report	3.3.1.B C	Within 90 calendar days of DHCS' request. Annually.		DHCS
D.0036	Financial Incentive Programs Report	3.3.3	As specified by DHCS.		DHCS
D.0037	Identification of Responsible Payor	3.3.4	Upon request and in a manner prescribed by DHCS.		DHCS' fiscal intermediary (FI) contractor

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0038	Documentation of services for Contractor's Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Network Provider Agreements	3.3.7.B	Within 30 calendar days of DHCS' request.		DHCS
D.0039	Certification of Terms and Conditions for Network Provider Agreements with FQHCs and RHCs	3.3.7.B	Within 30 calendar days of DHCS' request.		DHCS
D.0040	FQHC and RHC Network Provider Agreements	3.3.7.B	Whenever any Network Provider Agreements are executed or amended.		DHCS
D.0041	Disputed Emergency Services/Post-Stabilization Care Claims	3.3.16	As needed. Within 30 calendar days of the effective date of a decision that Contractor is liable for payment of a claim.		DHCS - Office of Administrative Hearings and Appeals

EXHIBIT A, ATTACHMENT III – 4.1 MARKETING

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0042	Request to Conduct Activity Outside of Contract Requirements	4.1.2	As needed, at least 30 calendar days prior to the Marketing event.		DHCS
D.0043	Updates to Marketing Representative Training and Certification Program	4.1.1	Prior to implementation.		DHCS
D.0044	Marketing Materials	4.1.2	Prior to distribution. At least 30 calendar days prior to the Marketing activity, unless DHCS agrees to a shorter review period.		DHCS
D.0045	Marketing Plan	4.1.2	Annually. When there are any changes made to Contractor's Marketing plan.		DHCS

EXHIBIT A, ATTACHMENT III – 4.2 ENROLLMENTS AND DISENROLLMENTS

No deliverables or requirements listed for this Section.

EXHIBIT A, ATTACHMENT III – 4.3 POPULATION HEALTH MANAGEMENT AND COORDINATION OF CARE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0046	Population Health Management Strategy	4.3.1	Annually.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0047	Population Needs Assessment	4.3.2	At least every three years.	On Contractor's website.	DHCS; Public
D.0048	Managed Care Liaison Change Notification	4.3.24	Within five days of the change.		DHCS

EXHIBIT A, ATTACHMENT III – 4.4 ENHANCED CARE MANAGEMENT

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0049	Enhanced Care Management Model of Care (MOC)	4.4.5	Contractor must submit to DHCS any Significant changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs.		DHCS

EXHIBIT A, ATTACHMENT III – 4.5 COMMUNITY SUPPORTS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0050	Community Supports Model of Care	4.5.5	Contractor must submit to DHCS any changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs.		DHCS

EXHIBIT A, ATTACHMENT III – 4.6 MEMBER GRIEVANCE AND APPEAL SYSTEM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0051	Receipt of StandardStandard Grievances	4.6.2.E	Within five calendar days of receipt of the Grievance.		Member who filed a Grievance

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0052	Discrimination Grievance Information	4.6.3.C	Within ten calendar days of mailing a Discrimination Grievance resolution letter. Contractor must also submit annual attestation 2*nd* Friday of December indicating MCP submitted appropriate grievance information to OCR within10 calendar days of mailing Discrimination Grievance resolution letter.	On Contractor's website.	DHCS - Office of Civil Rights; DHCS
D.0053	Sample Notice of Action (NOA) Letter	4.6.4.C 4.6.4.E .3	Within 30 calendar days from receipt of information that is reasonably necessary to make a determination. No later than 60 calendar days from the date on the NOA.		DHCS
D.0054	Grievance Logs	4.6.9	Upon DHCS request.		DHCS and/or CMS

EXHIBIT A, ATTACHMENT III – 5.1 MEMBER SERVICES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0056	Nondiscrimination Notice and Language Taglines	5.1.3	Prior to use.	On Contractor's website – accessible from Contractor's home page.	DHCS
D.0057	Member Information - Provider Directory	5.1.3	Prior to initial Operations; Monthly; Every six months; and When Contractor updates the Provider Directory. One week after Contractor receives updated provider information.	On Contractor's website.	DHCS; Public
D.0058	Member Information - Member Handbook/Evidence of Coverage (EOC)	5.1.3	Before distribution to Members; When updated; or Other timeframes provided by DHCS.	On Contractor's website.	DHCS
D.0129	EOC Attestation-Notification to DHCS that the EOC has been mailed and/or posted on the ~~MCP~~ Contractor's Website.	5.1.3	Annually, by January 1.	On Contractor's website	DHCS

EXHIBIT A, ATTACHMENT III – 5.2 NETWORK AND ACCESS TO CARE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0059	Alternative Access Standard Requests	5.2.5	At least annually and when Contractor is unable to comply with the time or distance standards set forth in W&I section 14197.04.	Contractor's website for Contractor specific results and the DHCS website with statewide results.	DHCS
D.0060	Network and Access Changes to Covered Services	5.2.9.A	When Contractor discovers a Provider-initiated termination impacting more than 2,000 Members; When Contractor discovers a Provider-initiated termination that affect Contractor's ability to meet network adequacy standards; When there is a change in the availability or location of Covered Services; and Within ten calendar days of Contractor discovering a Provider's exclusionary status from any database or list.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0061	Notification regarding Community Based Adult Services (CBAS) Network Provider	5.2.9.A	When Contractor is unable to contract with a certified CBAS Provider; Upon termination of a CBAS Network Provider Agreement; and Within five Working Days of Contractor's decision to exclude a CBAS Provider from its Network.		DHCS
D.0062	Notification regarding Long-Term Care (LTC) Network Provider	5.2.9.A .4	Within 60 calendar days of termination of a LTC Provider; Immediately if the termination is a result of LTC Provider decertification by CDPH; and Within 72 hours of applicable termination of a LTC Provider.		DHCS
D.0063	Member Notice regarding Provider Termination	5.2.9.B	Prior to its release to Members.		DHCS
D.0064	Community Advisory Committee (CAC) Demographic Report	5.2.11	Annually, by April 1st.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0065	CAC meeting notices	5.2.11	30 days prior to each quarterly CAC meeting, but in no event later than 72 hours prior to each meeting.	On Contractor's website.	Public
D.0066	CAC meeting minutes	5.2.11. E.3)d)	No later than 45 calendar days after each quarterly meeting.	On Contractor's website.	DHCS; Public
D.0067	Network Certification Report	5.2.13	At least annually.	On the DHCS Website.	DHCS
D.0068	Notification of Significant Change to Network	5.2.13. B	Any time there is a Significant Change to Contractor's Network that affects Network capacity and Contractor's ability to provide health care services.		DHCS
D.0069	Network Change Report	5.2.13	30 calendar days following the end of the reporting quarter.		DHCS
D.0112	Subcontractor and Downstream Subcontractor Certification Report	5.2.13	At least annually, if applicable.	On Contractor's website.	DHCS

EXHIBIT A, ATTACHMENT III – 5.3 SCOPE OF SERVICES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0070	Report of Drug Use Review (DUR) Program Activities	5.3.7.H	Annually.		DHCS

EXHIBIT A, ATTACHMENT III – 5.4 COMMUNITY BASED ADULT SERVICES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0072	CBAS Member Enrollment Report	5.4.3.A	On a quarterly basis.		DHCS
D.0113	Summary of CBAS Complaints	5.4.3.C	30 calendar days following the end of the reporting period.		DHCS
D.0073	CBAS Grievance and Appeal Reports	5.4.3.D	30 calendar days following the end of the reporting period.		DHCS
D.0120	CBAS Provider List	5.4.3.E	Annually.		DHCS

EXHIBIT A, ATTACHMENT III – 5.5 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

No deliverables or requirements listed for this Section.

EXHIBIT A, ATTACHMENT III – 5.6 MOUs WITH LOCAL GOVERNMENT AGENCIES, COUNTY PROGRAMS, AND THIRD PARTIES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0130	Revised MOU Template	5.6.1.C .2	As needed.	After execution	DHCS
D.0128	MOU Public Posting	5.6.2.D	Upon completed execution of contract.	Executed MOUs must be publicly posted	Public and DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0075	Status Report	5.6.3	Quarterly, beginning four months after the effective date of this Contract or within the timeframe required under this Contract and relevant APL, until all required MOUs are executed.		DHCS
D.0127	MOU Liaison Change Notification	5.6.3.A.3	Within five Working Days of any change in the designated MOUs' liaison.		DHCS
D.0121	Existing MOU	5.3.6.A.6	Within ten Working Days of receipt of the request.		DHCS
D.0076	Copy of Executed MOUs	5.6.3	Upon execution, modification or renewal.	On Contractor's website.	DHCS
D.0077	MOU Review Report	5.6.3.B	Annually.		DHCS, upon request

EXHIBIT A, ATTACHMENT III – 6.1 EMERGENCY PREPAREDNESS AND RESPONSE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0078	Emergency Preparedness and Response Plan	6.1	Prior to the start of Operations.	On Contractor's website.	DHCS
D.0079	Emergency Contact Information Update	6.1.2.A	No less than every six months; and As changes occur.		DHCS
D.0080	Cooperative Agreements	6.1.2.D	At least annually.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0081	Emergency Drill Report	6.1.2.E	Within 30 calendar days after the drill is completed.		DHCS
D.0082	Member Emergency Preparedness Plan Templates	6.1.3	Prior to use for each mode of communication.		DHCS
D.0083	Daily Emergency Reporting	6.1.5.B	Once a day, at a minimum, throughout the State of Emergency.		DHCS

EXHIBIT B, BUDGET DETAIL AND PAYMENT PROVISIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0084	Supplemental Payments Report	1.1.7.A	On a monthly basis no later than 20 calendar days following the end of each month.		DHCS
D.0085	Supplement Payment Eligibility Data	1.1.7.A	Contractor must properly submit all required data to DHCS within 12 months of the month of the service entitling Contractor to a Supplemental Payment.		DHCS
D.0086	Additional Payments Report	1.1.8.A	On a monthly basis, no later than 20 calendar days following the end of each month.		DHCS

Back to Agenda Back to Item

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0087	Additional Payments Report Eligibility Data	1.1.8. A	Contractor must properly submit all required data to DHCS within 12 months of the month of the service entitling Contractor to an additional payment.		DHCS
D.0122	Financial Performance Guarantee	1.1.12	Annually.		DHCS
D.0088	Medical Loss Ratio Remittance	1.1.15	When the ratio for the MLR reporting year does not meet the minimum MLR standard.		DHCS

EXHIBIT C, GENERAL TERMS AND CONDITIONS

No deliverables or requirements listed for this Exhibit.

EXHIBIT D(f), SPECIAL TERMS AND CONDITIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0094	Request for Subcontract Authorization	5.a	Before Contractor enters into or is reimbursed for any subcontract for services costing $5,000 or more.		DHCS
D.0096	Requests for Disclosure of Confidential Information	14	As applicable.		DHCS
D.0097	Contractor Certification of Federal Fund Expenditure	17.c	As applicable.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0098	Financial and Compliance Audit Reports	17.d	Within 30 calendar days after the completion of the audit.		DHCS
D.0099	Contractor Explanation for Debarment and Suspension Certification.	20	As applicable.		DHCS

EXHIBIT E, PROGRAM TERMS AND CONDITIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0123	Certifications - Data, Information, and Documentation Submitted to DHCS	1.1.11	Monthly.		DHCS
D.0100	Contractor's Analysis regarding its financial solvency	1.1.16	As needed.		DHCS
D.0101	Contractor Termination Notice due to financial insolvency	1.1.16	As needed, and at least six months prior to expected effective termination date.		DHCS
D.0124	Phaseout Transition Requirements	1.1.17. B	Within no later than 90 calendar days prior to termination or expiration of this Contract and through the Phaseout Period for each Service Area.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0102	Notice of Dispute	1.1.21. B	Within 30 calendar days from the date that the alleged dispute arises or otherwise becomes known to Contractor.		DHCS
D.0103	Costs Avoidance Reports	1.1.25	Within ten calendar days of discovery By the 15th day of each month.		DHCS
D.0104	Post-Payment Recovery Report	1.1.25. H 1.1.25. J	At the tenth day of each month; and Within ten calendar days of discovery when Contractor identifies OHC unknown to DHCS.		DHCS
D.0105	Service and Utilization Information	1.1.26	Within 30 calendar days of the DHCS' request.		DHCS
D.0125	Litigation Support Records	1.1.27. A	Upon DHCS request.		DHCS
D.0107	DVBE Reporting Requirements	1.1.31	60 calendar days after receiving final payment, if Contractor made a commitment to achieve DVBE participation.		DHCS

EXHIBIT F, CONTRACTOR'S RELEASE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0108	Contractor's Release	F	With the submission of final invoice(s).		DHCS

EXHIBIT G, BUSINESS ASSOCIATE ADDENDUM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0109	Notice to DHCS of Breaches and Security Incidents	18.1.1	See contract language for details.		DHCS
D.0110	Completed Final Privacy Incident Reporting Form	18.3	Within ten Working Days of the discovery of the security incident or breach.		DHCS

EXHIBIT H, CONFLICT OF INTEREST AVOIDANCE REQUIREMENTS

No deliverables or requirements listed for this Exhibit.

EXHIBIT I, CONTRACTOR'S PARENT GUARANTY REQUIREMENTS

No deliverables or requirements listed for this Exhibit.

EXHIBIT J, DELEGATION REPORTING AND COMPLIANCE PLAN

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0111	Delegation Reporting and Compliance Plan	3.1.3; Exh. J	Annually and at any time there is a change as specified by DHCS within 30 calendar days following the annual reporting period or the material change.	On Contractor's website.	DHCS; Public

EXHIBIT K, EXCLUDED PROVISIONS AS TO CONTRACTORS NOT LICENSED PURSUANT TO THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

No deliverables or requirements listed for this Exhibit.

EXHIBIT L, REQUIREMENTS SPECIFIC TO CONTRACTOR

Any deliverables for Contractor-specific requirements will be stated in Exhibit L.

Exhibit B – Budget Detail and Payment Provisions

1.0 Budget Detail and Payment Provisions

1.1 Budget Detail and Payment Provisions

1.1.1 Budget Contingency Clause
1.1.2 Contractor Risk
1.1.3 Capitation Payment Rates
1.1.4 Capitation Payment Rates Constitute Payment in Full
1.1.5 Determination and Redetermination of Capitation Payment Rates
1.1.6 Redetermination of Capitation Payment Rates Due to Obligation Changes
1.1.7 Supplemental Payments
1.1.8 Additional Payments
1.1.9 Recovery of Amounts Paid to Contractor
1.1.10 Reinsurance
1.1.11 Catastrophic Coverage Limitation
1.1.12 Financial Performance Guarantee
1.1.13 Medicare Coordination
1.1.14 Special Contract Provisions Related to Payment
1.1.15 Medical Loss Ratio Remittance
1.1.16 State Program Receiving Federal Financial Participation
1.1.17 Community Reinvestment
1.1.18 Quality Achievement Requirement
1.1.19 Enhanced Care Management Risk Corridor
1.1.20 Federally Qualified Health Center Alternative Payment Model Risk Corridor
1.1.21 Unsatisfactory Immigration Status Risk Corridor

1.1 Budget Detail and Payment Provisions

1.1.1 Budget Contingency Clause

Any requirement of payment or performance by DHCS and Contractor for the period of the Contract will be dependent upon the availability of future appropriations by the Legislature for the purpose of the Medi-Cal program.

A. It is mutually agreed that if the Budget Act of the current year or any subsequent years covered under this Contract does not appropriate sufficient funds for the program, DHCS has no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Contract, and Contractor is not obligated to perform any provisions of this Contract in any year when insufficient funding may occur. Further, should funding for any Fiscal Year be reduced or deleted by the Budget Act for purposes of this program, DHCS must have the option to:

1) Cancel this Contract with no liability accruing to DHCS and no further obligation by Contractor to perform hereunder; or

2) Offer a Contract amendment to Contractor to reflect the reduced amount of available funding.

B. All payments are subject to the availability of federal appropriation of Medicaid funding.

1.1.2 Contractor Risk

Except as otherwise specified in this Contract, Contractor will assume the total risk of providing Covered Services to Members on the basis of periodic Capitation Payments paid to Contractor by DHCS for each Member. Subject to Exhibit B, Section 1.1.15 (*Medical Loss Ratio Remittance*), any funds not expended by Contractor after having fulfilled all obligations under this Contract may be retained by Contractor.

1.1.3 Capitation Payment Rates

A. DHCS must remit to Contractor a Capitation Payment no later than 45 calendar days after the first day of each month for each Member that appears on the approved list of Members supplied to Contractor by DHCS. Capitation Payments must be made in accordance with the schedule of Capitation Payment rates set forth below. For the list of aid codes included in each Rate Group below, please see the definition of Potential Member set forth in Exhibit A, Attachment I, Section 1.0 (*Definitions*) of this

Back to Agenda Back to Item

Contract. Supplemental and Additional Payments listed below will be made in accordance to the requirements stated in Subsections 1.1.7 (*Supplemental Payments*) and 1.1.8 (*Additional Payments*) of this Exhibit.

For the period January 1, 2024 – December 31, 2024	**Orange**
Aid Group	**Rates**
Adult/Family/OTLIC Under 21 - SIS	$199.26
Adult/Family/OTLIC Under 21 - UIS	$109.70
Adult/Family/OTLIC 21 & Over - SIS	$401.77
Adult/Family/OTLIC 21 & Over - UIS	$309.70
SPD - SIS	$1,241.72
SPD - UIS	$735.64
BCCTP - SIS	$1,241.72
BCCTP - UIS	$735.64
SPD Dual - SIS	$584.50
SPD Dual - UIS	$161.81
LTC - SIS	$1,241.72
LTC - UIS	$735.64
LTC Dual - SIS	$584.50
LTC Dual - UIS	$161.81
Adult Expansion - SIS	$449.68
Adult Expansion - UIS	$378.90
WCM - SIS	$2,252.84
WCM - UIS	$612.50

For the period January 1, 2024 – December 31, 2024	**Orange**
Supplemental and Additional Payment Groups	**Rates**
Maternity - SIS	$8,811.73
Maternity - UIS	$8,811.73
Adult Expansion Maternity - SIS	$8,811.73
Adult Expansion Maternity - UIS	$8,811.73

B. If DHCS creates a new aid code that is split or derived from an existing aid code covered under this Contract, and the aid code has a neutral Contract Revenue effect for Contractor, then the split aid code will automatically be included in the same Rate Group as the original aid code covered under this Contract. Contractor agrees to accept the Capitation Payment rate specified for the original aid code as payment in full for Members in the new aid code. DHCS must confirm all aid code splits and the rates of payment for such new aid codes in writing to Contractor as soon as practicable after such aid code splits occur.

Back to Agenda Back to Item

C. In accordance with 42 Code of Federal Regulations (CFR), part 438, section 438.7, the actuarial basis for the computation of Capitation Payment rates must be set forth in DHCS' rate certification(s) for the applicable Rating Period. Subject to approval by Centers for Medicare & Medicaid Services (CMS), said rate certification(s) are hereby incorporated by reference and made a part of this Contract by this reference as if attached hereto in full.

1.1.4 Capitation Payment Rates Constitute Payment in Full

Except as otherwise specified in this Contract, Capitation Payment rates for each Rating Period, as calculated by DHCS and approved by CMS, are prospective rates and constitute payment in full on behalf of a Member for all Covered Services required by such Member and for all Administrative Costs incurred by Contractor in providing or arranging for such services under the terms of this Contract. Except as otherwise specified in this Contract, DHCS is not responsible for making payments associated with Contractor's losses.

1.1.5 Determination and Redetermination of Capitation Payment Rates

A. In accordance with Welfare and Institutions Code (W&I) section 14301.1, DHCS must establish Capitation Payment rates on an actuarial basis for each Rating Period, and reserves the right to redetermine and to amend such rates as necessary and appropriate.

1) DHCS must establish Capitation Payment rates in accordance with W&I section 14301.1, applicable federal and State laws and regulations, and generally accepted actuarial principles and practices.

2) DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider Contractor's performance on specified quality and equity benchmarks, as determined by DHCS and communicated to Contractors in advance of each applicable Rating Period, within the determination of Capitation Payment rates for that Rating Period.

3) If Contractor delegates financial risk for the provision of Covered Services in accordance with Exhibit A, Attachment III, Subsection 3.1.6 (*Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers*), DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider the actual payments received

Back to Agenda Back to Item

by Providers for providing Covered Services to Members to inform the determination of Capitation Payment rates.

B. Capitation Payment rates must be effectuated through an amendment or change order to this Contract in accordance with Exhibit E, Subsection 1.1.6 (*Amendment and Change Order Process*) of this Contract, subject to the following provisions:

1) The amendment or change order is effective as of January 1 of each year covered by this Contract;

2) In the event there is any delay in a determination or redetermination of Capitation Payment rates so that an amendment or change order may not be processed in sufficient time to permit payment of new rates commencing January 1, payment to Contractor must continue at the rates stated in an R Letter sent to Contractor by DHCS. The R Letter serves as notification from DHCS to Contractor of the Capitation Payment rates and the time period for which these rates will be applied. The R Letter must not be considered exempt from any requirement of this Contract. Those continued payments constitute interim payment only. Upon CMS final approval of the amendment/change order and rate certification providing for the rate change, DHCS must make retroactive adjustments for those months for which interim payment was made;

3) By accepting payment of new Capitation Payment rates prior to approval by CMS of the amendment/change order to this Contract implementing such new rates, Contractor stipulates to a confession of judgment for any and all amounts received in excess of the final approved rate. In the event that the final approved rate differs from the rates established by DHCS or agreed upon by Contractor and DHCS:

a) Any underpayment by DHCS must be paid to Contractor after final approval of the new rates. DHCS will provide Contractor a timeframe for payment of any underpayments;

b) Unless otherwise required by CMS, any overpayment to Contractor must be offset by DHCS' withholding from Contractor's future Contract Revenues of any amount due. DHCS may, at its sole discretion, withhold up to 100 percent of Contract Revenues for each month until any overpayment is fully recovered by the State; and

Back to Agenda Back to Item

c) Contractor must review all Contract Revenues and notify DHCS of any payment errors in a form and manner specified by DHCS. If the error favors DHCS, DHCS may offset against future Contract Revenues as stated in paragraph (b) above. If the error favors Contractor, Contractor must notify DHCS within 365 calendar days of payment, otherwise Contractor forfeits the right to receive the corrected payment, except when Contractor demonstrates to DHCS' satisfaction, in a form and manner specified by DHCS, that Contractor could not reasonably have identified the error.

4) If mutual agreement between DHCS and Contractor cannot be attained on Capitation Payment rates in accordance with this Paragraph B, Contractor has the right to terminate this Contract. Contractor's notification of the intent to terminate this Contract must be in writing and provided to DHCS at least nine months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with the terms set forth in Exhibit E, Subsection 1.1.16 (*Termination*) of this Contract. DHCS must pay Capitation Payment rates determined for the applicable Rating Periods until the Contract is terminated; and

5) DHCS must make reasonable efforts to notify and consult with Contractor regarding any proposed redetermination of Capitation Payment rates in accordance with this provision or Exhibit B, Subsection 1.1.6 (*Redetermination of Capitation Payment Rates Due to Obligation Changes*) below prior to implementation of any new rates.

1.1.6 Redetermination of Capitation Payment Rates Due to Obligation Changes

Final Capitation Payment rates may be adjusted during or subsequent to the applicable Rating Period to provide for changes in obligations that result in a material projected increase or decrease of cost as determined by the certifying actuaries, in accordance with W&I section 14301.1, to Contractor. Any adjustments must be effectuated through an amendment or change order to the Contract subject to the following:

A. The amendment or change order is effective as of the first day of the month in which the change in obligations is effective, as determined by DHCS;

B. In accordance with Subsection 1.1.5 *(Determination and Redetermination of Capitation Payment Rates*) of this Exhibit B, in the event DHCS is

Back to Agenda Back to Item

unable to process the amendment or change order in sufficient time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor must continue at the rates then in effect. Upon final approval of the amendment or change order, DHCS must make adjustments for those months in which interim payments were made; and

C. DHCS and Contractor may negotiate an earlier termination date, pursuant to Exhibit E, Subsection 1.1.16 (*Termination)* of this Contract, in the event a change in contractual obligations is created by a State or federal change in the Medi-Cal program, or by a lawsuit that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the termination date provided by this Contract.

1.1.7 Supplemental Payments

A. Contractor is entitled to Supplemental Payments stated within this Section in accordance with the schedule of Supplemental Payment rates set forth in this Exhibit B, Subsection 1.1.3 (*Capitation Payment Rates*). Contractor must maintain evidence of payment for qualified services entitling Contractor to Supplemental Payments. Upon audit, Contractor's failure to have supporting records may result in recoupment by DHCS of Supplemental Payments paid to Contractor.~~.~~

1) On a monthly basis, by no later than 20 calendar days following the end of each month, and in a format specified by DHCS, Contractor must submit a report for Supplemental Payments. This report must identify the Members receiving services qualifying for a Supplemental Payment and for whom Contractor is claiming payment.

2) To be eligible to receive a Supplemental Payment, Contractor must properly submit all required data to DHCS within 12 months of the month of the service entitling Contractor to a Supplemental Payment.

B. **Maternity Supplemental Payments**

1) Contractor is entitled to receive maternity Supplemental Payments for Members enrolled with Contractor on the date of the delivery of a Child, including retroactive Enrollments.

Back to Agenda Back to Item

2) The maternity Supplemental Payment reimburses Contractor for the projected cost of delivery as determined by DHCS.

1.1.8 Additional Payments

A. Contractor is entitled to additional payments stated within this Section in accordance with the schedule of additional payment rates set forth below. Contractor must maintain evidence of payment for qualified services entitling Contractor to additional payments. Upon audit, Contractor's failure to have supporting records may result in recoupment by DHCS of additional payments paid to Contractor.

1) On a monthly basis, by no later than 20 calendar days following the end of each month and in a format specified by DHCS, Contractor must submit a report for additional payments. This report must identify the Members receiving services qualifying for any additional payment and for whom Contractor is claiming payment.

2) To be eligible to receive an additional payment, Contractor must properly submit all required data to DHCS within 12 months of the month of the service entitling Contractor to an additional payment.

B. Contractor is entitled to receive an IHCP payment for Members qualified to receive services in accordance with Exhibit A, Attachment III, Subsection 3.3.7.C (*Indian Health Care Providers*) of this Contract.

1) DHCS will annually publish the IHCP payment rates via an All Plan Letter (APL).

2) The IHCP payment reimburses Contractor for the amount paid to the IHCPs as required in Exhibit A, Attachment III, Subsection 3.3.7 *(Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider)* of this Contract. Payments must be based on Member utilization of qualifying services at IHCPs as reported by Contractor.

1.1.9 Recovery of Amounts Paid to Contractor

DHCS has the right to recover from Contractor amounts paid to Contractor in the following circumstances:

A. If DHCS determines that a Member has been improperly enrolled due to ineligibility of the Member to enroll in Contractor's Medi-Cal managed care health plan, a Member's residence is outside of Contractor's Service Area,

or, pursuant to 22 California Code of Regulations (CCR) section 53891(a)(2), or a Member should have been disenrolled with an effective date in a prior month, DHCS may recover amounts paid to Contractor associated with the Member for the month(s) in question. To the extent permitted by law, Contractor may seek to recover any payments made to Providers for Covered Services rendered for the month(s) in question. Contractor must inform Providers that claims for services provided to Members during the month(s) in question may be paid by the DHCS fiscal intermediary if the Member is determined eligible for the Medi-Cal program;

B. Upon request by Contractor, DHCS may allow Contractor to retain amounts paid to Contractor associated with a Member who is eligible to enroll in Contractor's Medi-Cal managed care health plan, but should have been retroactively disenrolled in accordance with Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*) of this Contract or under other circumstances as approved by DHCS. If Contractor retains Capitation Payments, Supplemental Payments, and any other additional payments, Contractor must provide or arrange and pay for all Medically Necessary Covered Services for the Member until such Member is disenrolled on a non-retroactive basis pursuant to the terms set forth in Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*) of this Contract;

C. As a result of Contractor's failure to perform contractual responsibilities to comply with mandatory federal Medicaid requirements, the United States Department of Health and Human Services (U.S. DHHS) may disallow Federal Financial Participation (FFP) for payments made by DHCS to Contractor. In this event, DHCS may recover the amounts disallowed by U.S. DHHS by imposing an offset to Contract Revenues. If recovery of the full amount at one time imposes a financial hardship on Contractor, Contractor may request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six months. DHCS, at its sole discretion, may grant or deny such a request; and

D. If DHCS determines that any other erroneous or improper payment(s) not mentioned above has been made to Contractor, DHCS may recover all such determined amounts by the imposition of an offset to Contract Revenues. At least 30 calendar days prior to seeking any such recovery, DHCS must notify Contractor of the improper or erroneous nature of the payment, and must describe the recovery process. If recovery of the full amount at one time imposes a financial hardship on Contractor, Contractor may request to repay the recoverable amounts in monthly

installments over a period of consecutive months not to exceed six months. DHCS, at its sole discretion, may grant or deny such a request.

1.1.10 Reinsurance

In accordance with 22 CCR section 53252, Contractor may obtain reinsurance (i.e., stop loss coverage) to ensure maintenance of adequate capital by Contractor for the cost of providing Covered Services under this Contract, subject to the following conditions:

A. Reinsurance must not reduce Contractor's liability below $5,000 per Member for any one 12-month period.

B. Reinsurance may cover both of the following:

1) The total cost of services provided to Members under emergency circumstances by non-contracted Providers, including the cost of inpatient care in a non-contracted facility until such time as the Member may be safely transported to a Network facility; and

2) Up to 90 percent of all expenditures related to this Contract exceeding 115 percent of Contract Revenues and third-party recoveries during any Fiscal Year of Contractor.

C. At its sole discretion and determination, and following consultation with Contractor, DHCS may require Contractor to retain appropriate reinsurance coverage for high-cost Members or services.

1.1.11 Catastrophic Coverage Limitation

DHCS may limit Contractor's liability to provide or arrange and pay for health care services for illness of, or injury to Members, resulting from or greatly aggravated by a catastrophic occurrence or disaster which occurs subsequent to Enrollment. Following the Director's invocation of this catastrophic coverage limitation, Contractor will return a prorated amount of the total Capitation Payment received by Contractor for the month. The amount returned will be determined by dividing the total Capitation Payment made to Contractor for such month by the number of days in that month, whereupon Contractor will return the

amount to DHCS for each day in of the month after the Director's invocation of this catastrophic coverage limitation.

1.1.12 Financial Performance Guarantee

A. In accordance with 22 CCR section 53865, Contractor must annually provide satisfactory evidence of, and maintain, a Financial Performance Guarantee in the form specified by DHCS and in an amount of at least one million dollars ($1,000,000) or equal to at least one month's Contract Revenues for each of Contractor's Service Areas, based on Contractor's average monthly Contract Revenues calculated for the previous twelve months of Contractor's operation, except that if Contractor has been operating for less that 12 months average monthly Contract Revenues will be calculated for as many months as Contractor has been operating, whichever is higher, and subject to approval by DHCS. In its discretion, DHCS may increase the required amount of the Financial Performance Guarantee for Contractor up to an amount of two million dollars ($2,000,000) or equal to two months' Contract Revenues for each of Contractor's Service Areas, based on Contractor's average monthly Contract Revenues for the previous twelve months, except that if Contractor has been operating for less that 12 months average monthly Contract Revenues will be calculated for as many months as Contractor has been operating, whichever is higher, for any material breach of this Contract.

B. At Contractor's request, and with DHCS approval, Contractor may establish a phase-in schedule to accumulate the required Financial Performance Guarantee. Contractor may elect to satisfy the Financial Performance Guarantee requirement by receiving payment on a post payment basis, subject to DHCS approval.

C. DHCS must take possession of the Financial Performance Guarantee in an amount sufficient to indemnify DHCS in the event that Contractor materially breaches or defaults on one or more terms in this Contract. Unless DHCS has a financial claim or offset against Contractor in which case DHCS may immediately enforce its rights under the Financial Performance Guarantee, the Financial Performance Guarantee must remain in effect through the completion of the Phaseout Period in accordance with Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

1.1.13 Medicare Coordination

In accordance with 42 CFR section 438.3(t), Contractor must enter into a Coordination of Benefits Agreement with the Medicare program through CMS, and must agree to participate in Medicare's automated claims crossover process for full benefit dual eligible Members.

1.1.14 Special Contract Provisions Related to Payment

A. Contractor must reimburse Network Providers pursuant to the terms of each of the following applicable Pass-Through Payments established pursuant to 42 CFR section 438.6(d), in accordance with the CMS-approved rate certification, and in a form and manner specified by DHCS through APLs or other technical guidance:

1) Private Hospital and District and Municipal Public Hospital (DMPH) Pass-Through Payments, which requires Contractor to make increased payments to private hospitals and DMPHs in accordance with DHCS guidance.

2) Martin Luther King Jr. (MLK) Community Hospital Pass-Through Payment, which requires Contractor to make increased payments to MLK Community Hospital in Los Angeles County in accordance with W&I section 14165.50 and DHCS guidance.

3) Benioff Children's Hospital Oakland (BCHO) Pass-Through Payment, which requires Contractor to make increased payments to BCHO in Alameda County in accordance with DHCS guidance.

4) Distinct Part Nursing Facilities Pass-Through Payment, which requires Contractor to make increased payments to select publicly owned hospitals in accordance with DHCS guidance.

B. Contractor must reimburse Providers pursuant to the terms of each applicable Directed Payment Initiative in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each Directed Payment Initiative, including the Directed Payment Initiative preprint as applicable, available

Back to Agenda Back to Item

on the DHCS website at https://www.dhcs.ca.gov. Directed Payment Initiatives are subject to change and currently include:

1) Designated Public Hospital (DPH) Enhanced Payment Program (EPP), which requires Contractor to make uniform dollar or percentage increase payments to DPH systems for every qualifying service or assigned Member months in accordance with DHCS guidance, including but not limited to APL 21-018, the Directed Payment Initiative preprint, and W&I section 14197.4(b).

2) Private Hospital Directed Payments Program (PHDP), which requires Contractor to make uniform dollar increase payments to eligible private hospitals for every qualifying service in accordance with DHCS guidance, including but not limited to APL 21-018 and the Directed Payment Initiative preprint.

3) District Hospital Directed Payments Program (DHDP), which requires Contractor to make uniform dollar increase payments to eligible DMPHs for every qualifying service in accordance with DHCS guidance, including but not limited to APL 21-018 and the Directed Payment Initiative preprint.

4) DPH Quality Incentive Pool (QIP), which requires Contractor to make performance-based quality incentive payments to DPH systems based on DHCS' evaluation of DPH systems' performance on specified quality measures in accordance with DHCS guidance, including but not limited to APL 21-018, the Directed Payment Initiative preprint, and W&I section 14197.4(c).

5) DMPH QIP, which requires Contractor to make performance-based quality incentive payments to DMPH systems based on DHCS' evaluation of DMPH systems' performance on specified quality measures in accordance with DHCS guidance, including but not limited to APL 21-018, the Directed Payment Initiative preprint, and W&I section 14197.4(c).

6) Directed Payments for Developmental Screening Services, which requires Contractor to make uniform dollar increase payments to eligible Network Providers for every adjudicated claim for specified developmental screening services in accordance with DHCS guidance, including but not limited to APL 23-016, the Directed Payment Initiative preprint, and W&I section 14105.197(a)(3).

7) Directed Payments for Adverse Childhood Experiences (ACEs), which requires Contractor to pay eligible Network Providers at no

less than the California Medicaid State Plan approved rates for every adjudicated claim for specified ACEs screening services in accordance with DHCS guidance, including but not limited to APL 23-017, and W&I section 14105.197(a)(4).

8) Proposition 56 Directed Payments for Family Planning Services, which requires Contractor to make uniform dollar increase payments to eligible Providers for every adjudicated claim for specified family planning services in accordance with DHCS guidance, including but not limited to APL 23-008 and the Directed Payment Initiative preprint.

9) Organ and Bone Marrow Transplants, which requires Contractor to pay eligible contracted and non-contracted Providers amounts equivalent to the California Medicaid State Plan approved rates, or amounts equivalent to the rates published by DHCS for University of California system facilities furnishing subject services, for specified organ and bone marrow transplant services using the methodology developed and published by DHCS on an annual basis in accordance with DHCS guidance, including but not limited to APL 21-015, the Directed Payment Initiative preprint, and W&I section 14184.201(d).

10) LTC FFS-Equivalent Base Directed Payment, which requires Contractors to pay Network Providers, in specified counties where services were traditionally covered in the FFS delivery system, at exactly the California Medicaid State Plan approved case or service rates for Skilled Nursing Facility (SNF) services and Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N) services and Subacute (adult and pediatric) services. In all other counties, it requires Contractors to pay Network Providers at no less than the California Medicaid State Plan approved rates for SNF services and ICF/DD, ICF/DD-H, and ICF/DD-N services and Subacute (adult and pediatric) services at minimum. All payments must be made in accordance with DHCS guidance, including but not limited to APL 23-004, the Directed Payment Initiative preprint, and W&I section 14184.201(b) – (c).

11) Workforce Quality Incentive Program (WQIP), which requires Contractor to make uniform dollar increase payments to eligible Network Providers for every qualifying service adjusted based on DHCS' evaluation of their performance on specified quality and workforce measures in accordance with DHCS through APLs or

other guidance, the Directed Payment Initiative preprint, and W&I section 14126.024.

12) In accordance with W&I section 5961.4(c), and for applicable dates of service, Contractor must reimburse Providers of Medically Necessary outpatient mental health or SUD treatment provided at a School Site to a Member who is a student 25 years of age or younger at least at the fee schedule rate or rates developed by the Department in accordance with W&I section 5961.4(a), as defined by DHCS in the California Medicaid State Plan, a Directed Payment Initiative, and other applicable guidance, but only to the extent Contractor is financially responsible for those School Site services under this Contract.

13) Equity and Practice Transformation Provider Directed Payment Program, which requires Contractor to pay performance-based quality incentive payments to Primary Care practices that provide pediatric, family medicine, internal medicine, or obstetrics and gynecology (OB/GYN) services Members based on DHCS' evaluation of Provider performance on specified quality measures in accordance with the Directed Payment Initiative preprint and in a form and manner specified by DHCS through APLs or other guidance.

14) Targeted Rate Increases require Contractor to pay eligible Network Providers at no less than the California Medicaid State Plan approved rates for specified primary care services, including those provided by physician and non-physician professionals, obstetric services, including Doula services, and non-specialty mental health services, in accordance with W&I Section 14105.201, and in a form and manner specified by DHCS through APL~~s~~ 24-007 or other guidance.

15) Children's Hospital Supplemental Payment (CHSP), which requires Contractor to make uniform dollar increase payments to Children's Hospitals, as defined in W&I section 10727, for each qualifying service in accordance with DHCS guidance, including but not limited to APL 21-018 and the Directed Payment Initiative preprint.

16) Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM), which requires Contractor to make capitated payments to participating FQHCs for each Member assigned to that FQHC, in accordance with W&I, Article 4.1

Back to Agenda Back to Item

(commencing with Section 14138.1) of Chapter 7 of Part 3 of Division 9, and Attachment 4.19-B, pages 6AA7-6AA17, of the California Medicaid State Plan, and direction provided by DHCS through APLs or other guidance.

C. Contractor must comply with the terms of any Risk Sharing Mechanisms instituted in accordance with 42 CFR section 438.6(b)(1), in a form and manner specified by DHCS through APLs or other technical guidance.

D. Contractor must comply with the terms of any applicable Incentive Arrangements approved by CMS under 42 CFR section 438.6(b)(2), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each approved Incentive Arrangement available on the DHCS website. Incentive Arrangement payments must not exceed 105 percent of the approved Capitation Payments attributable to the Enrollees or services covered by the Incentive Arrangement, as specified in 42 CFR section 438.6(b)(2) and as calculated by DHCS. DHCS may impose a cap on incentive payments and/or participation in applicable Incentive Arrangements if DHCS determines that the incentive payment(s) are likely to exceed 105 percent of the approved Capitation Payments. Contractor will be required to remit to DHCS any incentive payment amounts in excess of 105 percent of approved Capitation Payments. Incentive Arrangements are subject to change in accordance with the requirements of 42 CFR section 438.6(b)(2). Current Incentive Arrangements include:

1) California Advancing and Innovating Medi-Cal (CalAIM) Incentive Payment Program, through which Contractor may earn incentive payments for achievement of specified CalAIM Incentive Payment Program milestones and metrics associated with implementation of CalAIM initiatives as determined by DHCS and in accordance with DHCS guidance, including but not limited to the CalAIM Incentive Payment Program terms specified on the DHCS website, APL 23-003, and W&I section 14184.207.

2) Student Behavioral Health Incentive Program (SBHIP), through which Contractor may earn incentive payments for achievement of specified milestones and metrics associated with targeted interventions that increase access to preventive, early intervention, and Behavioral Health Services by school-affiliated Behavioral Health Providers as determined by DHCS and in accordance with the terms on the DHCS website, W&I section 5961.3, and APL 23-035.

3) The Quality Withhold and Incentive Program, which consists of a Withhold Arrangement as described in Paragraph E below, and an Incentive Arrangement through which Contractor may earn incentive payments for achievement of certain targets associated with quality scoring from Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) related data, as determined by DHCS and in accordance with the terms on the DHCS website, W&I section 14301.1(e) and (o)(4), and in a form and manner specified through APLs or other guidance.

E. Contractor must comply with the terms of any applicable Withhold Arrangement approved by CMS under 42 CFR section 438.6(b)(3), in a form and manner specified by DHCS through APLs or other guidance. For applicable Rating Periods, DHCS will make the terms of each approved Withhold Arrangement available on the DHCS website.

1) The Withhold Arrangement must ensure that the Capitation Payment, minus any portion of the withhold that is not reasonably achievable, is actuarially sound as determined by an actuary. The total amount of the withhold, achievable or not, will take into consideration the financial operating needs accounting for the size and characteristics of the populations covered under this Contract, as well as Contractor's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves.

2) Current Withhold Arrangements include the Quality Withhold and Incentive Program, which consists of an Incentive Arrangement as described in this Paragraph E, and a Withhold Arrangement through which Contractor may earn back the entire Capitation Payment withheld, or portion thereof, for achievement of certain targets associated with quality scoring from HEDIS® and CAHPS® related data, as determined by DHCS and in accordance with DHCS guidance, including but not limited to the terms on the DHCS website, W&I section 14301.1(e) and (o)(4), and in a form and manner specified in APLs or other guidance.

1.1.15 Medical Loss Ratio Remittance

In accordance with W&I section 14197.2(c)(1), Contractor must provide a remittance to DHCS for a Medical Loss Ratio (MLR) reporting year if the MLR

reported in accordance with Exhibit A, Attachment III, Subsection 1.2.5 (*Medical Loss Ratio*) for that MLR reporting year does not meet the minimum MLR standard of 85 percent. DHCS must validate Contractor's reported remittance amount pursuant to Exhibit A, Attachment III, Subsection 1.2.5 (*Medical Loss Ratio*) and determine the final remittance amount owed by Contractor for each MLR reporting year and rating region. Starting January 1, 2025, Contractor must impose equivalent remittance requirements on its Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

1.1.16 State Program Receiving Federal Financial Participation

Should any part of the scope of work under this contract relate to a State program receiving Federal Financial Participation (FFP) that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must cease its work on the part no longer authorized by law after the effective date of the loss of such program authority. DHCS must adjust Capitation Payments to remove costs that are specific to any State program or activity receiving FFP that is no longer authorized by law to receive FFP. If Contractor works on a State program or activity receiving FFP that is no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If DHCS has paid Contractor in advance to work on a no-longer-authorized State program or activity receiving FFP and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to DHCS. However, if Contractor worked on a State program or activity receiving FFP prior to the date legal authority ended for that State program or activity receiving FFP, and DHCS included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the State program or activity receiving FFP lost legal authority.

1.1.17 Community Reinvestment

A. Contractor must demonstrate a commitment to the local communities in which it operates through community reinvestment activities including contributing a set percentage of its annual net income under this Contract to community reinvestment, in accordance with the plan developed pursuant to Exhibit A, Attachment III, Subsection 1.2.7 (*Community Reinvestment Plan and Report*). This requirement is effective following Contractor's first year of operation as a Medi-Cal Managed Care Health Plan, as determined by DHCS. The percentage of Contractor's annual net income required to be contributed must be:

1) 5 percent of the portion of Contractor's annual net income that is less than or equal to 7.5 percent of Contract Revenues for the year; and

2) 7.5 percent of the portion of Contractor's annual net income that is greater than 7.5 percent of Contract Revenues for the year.

B. If Contractor has a Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor, Contractor must require all of its Fully Delegated Subcontractors or Downstream Fully Delegated Subcontractors to demonstrate a commitment to the local communities in which it operates through community reinvestment activities including contributing ~~f~~a set percentage of the Fully Delegated Subcontractor's or Downstream Fully Delegated Subcontractor's annual net income under the Fully Delegated Subcontractor's Subcontractor Agreement or Downstream Subcontractor's Downstream Subcontractor Agreement that is attributable to Members covered under this Contract to community reinvestment, in accordance with the plan developed pursuant to Exhibit A, Attachment III, Subsection 1.2.7 (*Community Reinvestment Plan and Report*). This requirement is effective following Contractor's first year of operation as a Medi-Cal Managed Care Health Plan, as determined by DHCS. The percentage of the Fully Delegated Subcontractor's or Downstream Fully Delegated Subcontractor's annual net income required to be contributed must be:

1) 5 percent of the portion of the Fully Delegated Subcontractor's or Downstream Fully Delegated Subcontractor's annual net income that is less than or equal to 7.5 percent of the amount the Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor is paid under its Subcontractor Agreement or Downstream Subcontractor Agreement with Contractor for the year; and

2) 7.5 percent of the portion of the Fully Delegated Subcontractor's or Downstream Fully Delegated Subcontractor's annual net income that is greater than 7.5 percent of the amount the Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor is paid under its Subcontractor Agreement or Downstream Subcontractor Agreement with Contractor for the year.

1.1.18 Quality Achievement Requirement

If Contractor does not meet quality outcome metrics as defined through an APL or similar guidance, it must contribute an additional 7.5 percent of its annual net income under this Contract to community reinvestment in accordance with the plan developed pursuant to Exhibit A, Attachment III, Subsection 1.2.7 (*Community Reinvestment Plan and Report*).

1.1.19 Enhanced Care Management Risk Corridor

A Risk Sharing Mechanism will be in effect for each of the Rating Periods covering dates of services from January 1, 2022, through December 31, 2025.

A. The Risk Sharing Mechanism described in this provision may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through APLs or other technical guidance.

B. The Risk Sharing Mechanism will be symmetrical and based on the results of an Enhanced Care Management (ECM) risk corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal Managed Care contracts between Contractor and the State for those capitation increments, services, and populations associated with ECM, as determined by DHCS.

C. Contractor must provide and certify allowable medical expense data as necessary for the ECM risk corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance, and may be subject to audit by the State or its designee.

D. DHCS or its designee will initiate the ECM Risk Corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.

1.1.20 Federally Qualified Health Center Alternative Payment Model Risk Corridor

A Risk Sharing Mechanism will be in effect for each of the Rating Periods that the Federally Qualified Health Center (FQHC) Alternative Payment Model (APM) is in effect in accordance with W&I section 14138.16.

A. The Risk Sharing Mechanism described in this Subsection may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through APLs or other technical guidance.

B. The Risk Sharing Mechanism will be symmetrical and based on the results of an FQHC APM risk corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal managed care contracts between Contractor and the State for those capitation increments, services, and populations associated with the FQHC APM, as determined by DHCS.

C. Contractor must provide and certify allowable medical expense data as necessary for the FQHC APM risk corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance, and may be subject to audit by the State or its designee.

D. DHCS or its designee will initiate the FQHC APM Risk Corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.

1.1.21 Unsatisfactory Immigration Status Risk Corridor

A Risk Sharing Mechanism will be in effect for each of the Rating Periods covering dates of services from January 1, 2024, through December 31, 2024.

A. The Risk Sharing Mechanism described in this Subsection may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through APLs or other technical guidance.

B. The Risk Sharing Mechanism will be symmetrical and based on the results of an Unsatisfactory Immigration Status (UIS) risk corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal managed care contracts between Contractor and the State for those capitation increments, services, and populations associated with UIS, as determined by DHCS.

C. Contractor must provide and certify allowable medical expense data as necessary for the UIS risk corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance, and may be subject to audit by the State or its designee.

D. DHCS or its designee will initiate the UIS risk corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.

Exhibit C – General Terms and Conditions

The entire General Terms and Conditions (GTC 04/2017) developed by the California Department of General Services (DGS) ("Exhibit C") is not included in this Contract. Instead, applicable terms and provisions from Exhibit C have been incorporated throughout this Contract.

In the event that DGS amends Exhibit C after the effective date of the Contract, Contractor agrees that DHCS, in its sole discretion, may incorporate future DGS amendments into this Contract through the issuance of an All Plan Letter (APL) or other similar instructions.

Exhibit D(f) – Special Terms and Conditions

This is version (Rev. 10/22)

Exhibit D(f)

Special Terms and Conditions

(For federally funded service contracts or agreements and grant agreements)

The use of headings or titles throughout this exhibit is for convenience only and not be used to interpret or to govern the meaning of any specific term or condition.

The terms "contract", "Contractor" and "Subcontractor" shall also mean, “agreement”, "grant", “grant agreement”, "Grantee" and "Subgrantee" respectively.

The terms “California Department of Health Care Services”, “California Department of Health Services”, ‘Department of Health Care Services”, “Department of Health Services”, “CDHCS”, “DHCS”, “CDHS”, and “DHS” shall all have the same meaning and refer to the California State agency that is a party to this Agreement.

This exhibit contains provisions that require strict adherence to various contracting laws and policies. Some provisions herein are conditional and only apply if specified conditions exist (i.e., agreement total exceeds a certain amount; agreement is federally funded, etc.). The provisions herein apply to this Agreement unless the provisions are removed by reference on the face of this Agreement, the provisions are superseded by an alternate provision appearing elsewhere in this Agreement, or the applicable conditions do not exist.

Index of Special Terms and Conditions

1. Federal Equal Employment Opportunity Requirements	20. Debarment and Suspension Certification
2. Travel and Per Diem Reimbursement	21. Smoke-Free Workplace Certification
3. Procurement Rules	22. Drug Free Workplace Act of 1988
4. Equipment Ownership / Inventory / Disposition	23. Covenant Against Contingent Fees
5. Subcontract Requirements	24. Payment Withholds
6. Income Restrictions	25. Performance Evaluation
7. Audit and Record Retention	26. Officials Not to Benefit
8. Site Inspection	27. Four-Digit Date Compliance
9. Federal Contract Funds	28. Prohibited Use of State Funds for Software
10. Termination	29. Use of Disabled Veteran's Business Enterprises (DVBE)
11. Intellectual Property Rights	30. Use of Small, Minority Owned and Women's Businesses
12. Air or Water Pollution Requirements	31. Alien Ineligibility Certification
13. Prior Approval of Training Seminars, Workshops or Conferences	32. Union Organizing
14. Confidentiality of Information	33. Contract Uniformity (Fringe Benefit Allowability)
15. Documents, Publications, and Written Reports	34. Suspension or Stop Work Notification
16. Dispute Resolution Process	35. Public Communications
17. Financial and Compliance Audit Requirements	36. Compliance with Statutes and Regulations
18. Human Subjects Use Requirements	37. Lobbying Restrictions and Disclosure Certification
19. Novation Requirements	

1. Federal Equal Opportunity Requirements

(Applicable to all federally funded agreements entered into by the Department of Health Care Services)

a. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices state the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

b. The Contractor will, in all solicitations or advancements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

c. The Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Contractor's commitments under the provisions herein and post copies of the notice in conspicuous places available to employees and applicants for employment.

d. The Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by

Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,‘ and as supplemented by regulation at 41 CFR part 60, “Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” and of the rules, regulations, and relevant orders of the Secretary of Labor.

e. The Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,‘ and as supplemented by regulation at 41 CFR part 60, “Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

f. In the event of the Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further federal and State contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,‘ and as supplemented by regulation at 41 CFR part 60, “Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

g. The Contractor will include the provisions of Paragraphs a through g in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,‘ and as supplemented by regulation at 41 CFR part 60, “Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event the Contractor becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, the Contractor

may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

(Applicable if travel and/or per diem expenses are reimbursed with agreement funds.)

Reimbursement for travel and per diem expenses from DHCS under this Agreement shall, unless otherwise specified in this Agreement, be at the rates currently in effect, as established by the California Department of Human Resources (CalHR), for nonrepresented State employees as stipulated in DHCS' Travel Reimbursement Information Exhibit. If the CalHR rates change during the term of the Agreement, the new rates apply upon their effective date and no amendment to this Agreement shall be necessary. Exceptions to CalHR rates may be approved by DHCS upon the submission of a statement by the Contractor indicating that such rates are not available to the Contractor. No travel outside the State of California shall be reimbursed without prior authorization from DHCS. Verbal authorization should be confirmed in writing. Written authorization may be in a form including fax or email confirmation.

3. Procurement Rules

(Applicable to agreements in which equipment/property, commodities and/or supplies are furnished by DHCS or expenses for said items are reimbursed by DHCS with State or federal funds provided under the Agreement.)

a. Equipment/Property definitions

Wherever the term equipment and/or property is used, the following definitions shall apply:

(1) **Major equipment/property**: A tangible or intangible item having a base unit cost of $5,000 or more with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement. Software and videos are examples of intangible items that meet this definition.

(2) **Minor equipment/property:** A tangible item having a base unit cost of less than $5,000 with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement.

b. Government and public entities (including State colleges/universities and auxiliary organizations), whether acting as a contractor and/or subcontractor, may secure all commodities, supplies, equipment and services related to such

Back to Agenda Back to Item

purchases that are required in performance of this Agreement. Said procurements are subject to Paragraphs d through h of Provision 3

c. Paragraph c of Provision 3 also apply, if equipment/property purchases are delegated to subcontractors that are nonprofit organizations or commercial businesses.

d. Nonprofit organizations and commercial businesses, whether acting as a contractor and/or subcontractor, may secure commodities, supplies, equipment/property and services related to such purchases for performance under this Agreement.

(1) Equipment/property purchases not exceed $50,000 annually.

To secure equipment/property above the annual maximum limit of $50,000, the Contractor make arrangements through the appropriate DHCS Program Contract Manager, to have all remaining equipment/property purchased through DHCS' Purchasing Unit. The cost of equipment/property purchased by or through DHCS be deducted from the funds available in this Agreement. Contractor submit to the DHCS Program Contract Manager a list of equipment/property specifications for those items that the State must procure. DHCS may pay the vendor directly for such arranged equipment/property purchases and title to the equipment/property will remain with DHCS. The equipment/property will be delivered to the Contractor's address, as stated on the face of the Agreement, unless the Contractor notifies the DHCS Program Contract Manager, in writing, of an alternate delivery address.

(2) All equipment/property purchases are subject to Paragraphs d through h of Provision 3. Paragraph b of Provision 3 also apply, if equipment/property purchases are delegated to Subcontractors that are either a government or public entity.

(3) Nonprofit organizations and commercial businesses use a procurement system that meets the following standards:

(a) Maintain a code or standard of conduct that govern the performance of its officers, employees, or agents engaged in awarding procurement contracts. No employee, officer, or agent shall participate in the selection, award, or administration of a procurement, or bid contract in which, to his or her knowledge, he or she has a financial interest.
(b) Procurements be conducted in a manner that provides, to the maximum extent practical, open, and free competition.

(c) Procurements be conducted in a manner that provides for all of the

following:

[1] Avoid purchasing unnecessary or duplicate items.

[2] Equipment/property solicitations be based upon a clear and accurate description of the technical requirements of the goods to be procured.

[3] Take positive steps to utilize small and veteran owned businesses.

e. Unless waived or otherwise stipulated in writing by DHCS, prior written authorization from the appropriate DHCS Program Contract Manager will be required before the Contractor will be reimbursed for any purchase of $5,000 or more for commodities, supplies, equipment/property, and services related to such purchases. The Contractor must provide in its request for authorization all particulars necessary, as specified by DHCS, for evaluating the necessity or desirability of incurring such costs. The term "purchase" excludes the purchase of services from a subcontractor and public utility services at rates established for uniform applicability to the general public.

f. In special circumstances, determined by DHCS (e.g., when DHCS has a need to monitor certain purchases, etc.), DHCS may require prior written authorization and/or the submission of paid vendor receipts for any purchase, regardless of dollar amount. DHCS reserves the right to either deny claims for reimbursement or to request repayment for any Contractor and/or subcontractor purchase that DHCS determines to be unnecessary in carrying out performance under this Agreement.

g. The Contractor and/or subcontractor must maintain a copy or narrative description of the procurement system, guidelines, rules, or regulations that will be used to make purchases under this Agreement. The State reserves the right to request a copy of these documents and to inspect the purchasing practices of the Contractor and/or subcontractor at any time.

h. For all purchases, the Contractor and/or subcontractor must maintain copies of all paid vendor invoices, documents, bids and other information used in vendor selection, for inspection or audit. Justifications supporting the absence of bidding (i.e., sole source purchases) also be maintained on file by the Contractor and/or subcontractor for inspection or audit.

i. DHCS may, with cause (e.g., with reasonable suspicion of unnecessary purchases or use of inappropriate purchase practices, etc.), withhold, cancel, modify, or retract the delegated purchase authority granted under Paragraphs b and/or c of Provision 3 by giving the Contractor no less than 30 calendar days written notice.

4. Equipment/Property Ownership / Inventory / Disposition

(Applicable to agreements in which equipment/property is furnished by DHCS and/or when said items are purchased or reimbursed by DHCS with State or federal funds provided under the Agreement.)

a. Wherever the term equipment and/or property is used in Provision 4, the definitions in Paragraph a of Provision 3 apply.

Unless otherwise stipulated in this Agreement, all equipment and/or property that is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement be considered State equipment and the property of DHCS.

(1) **Reporting of Equipment/Property Receipt**

DHCS requires the reporting, tagging and annual inventorying of all equipment and/or property that is furnished by DHCS or purchased/reimbursed with funds provided through this Agreement.

Upon receipt of equipment and/or property, the Contractor report the receipt to the DHCS Program Contract Manager. To report the receipt of said items and to receive property tags, Contractor use a form or format designated by DHCS' Asset Management Unit. If the appropriate form (i.e., Contractor Equipment Purchased with DHCS Funds) does not accompany this Agreement, Contractor request a copy from the DHCS Program Contract Manager.

(2) **Annual Equipment/Property Inventory**

If the Contractor enters into an agreement with a term of more than twelve months, the Contractor submit an annual inventory of State equipment and/or property to the DHCS Program Contract Manager using a form or format designated by DHCS' Asset Management Unit. If an inventory report form (i.e., Inventory/Disposition of DHCS-Funded Equipment) does not accompany this Agreement, Contractor request a copy from the DHCS Program Contract Manager. Contractor:

(a) Include in the inventory report, equipment and/or property in the Contractor's possession and/or in the possession of a subcontractor (including independent consultants).

(b) Submit the inventory report to DHCS according to the instructions appearing on the inventory form or issued by the DHCS Program Contract Manager.

(c) Contact the DHCS Program Contract Manager to learn how to remove, trade-in, sell, transfer or survey off, from the inventory report, expired equipment and/or property that is no longer wanted, usable or has passed its life expectancy. Instructions will be supplied by either the DHCS Program Contract Manager or DHCS' Asset Management Unit.

b. Title to State equipment and/or property not be affected by its incorporation or attachment to any property not owned by the State.

c. Unless otherwise stipulated, DHCS be under no obligation to pay the cost of restoration, or rehabilitation of the Contractor's and/or Subcontractor's facility which may be affected by the removal of any State equipment and/or property.

d. The Contractor and/or Subcontractor maintain and administer a sound business program for ensuring the proper use, maintenance, repair, protection, insurance and preservation of State equipment and/or property.

(1) In administering this provision, DHCS may require the Contractor and/or Subcontractor to repair or replace, to DHCS' satisfaction, any damaged, lost or stolen State equipment and/or property. In the event of State equipment and/or miscellaneous property theft, Contractor and/or Subcontractor immediately file a theft report with the appropriate police agency or the California Highway Patrol and Contractor promptly submit one copy of the theft report to the DHCS Program Contract Manager.

e. Unless otherwise stipulated by the Program funding this Agreement, equipment and/or property purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, only be used for performance of this Agreement or another DHCS agreement.

Within sixty (60) calendar days prior to the termination or end of this Agreement, the Contractor provide a final inventory report of equipment and/or property to the DHCS Program Contract Manager and, at that time, query DHCS as to the requirements, including the manner and method, of returning State equipment and/or property to DHCS. Final disposition of equipment and/or property be at DHCS expense and according to DHCS instructions. Equipment and/or property disposition instructions be issued by DHCS immediately after receipt of the final inventory report. At the termination or conclusion of this Agreement, DHCS may at its discretion, authorize the continued use of State equipment and/or property for performance of work under a different DHCS agreement.

f. **Motor Vehicles**

(Applicable only if motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under this Agreement.)

Back to Agenda Back to Item

(1) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, within thirty (30) calendar days prior to the termination or end of this Agreement, the Contractor and/or Subcontractor return such vehicles to DHCS and deliver all necessary documents of title or registration to enable the proper transfer of a marketable title to DHCS.

(2) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the State of California be the legal owner of said motor vehicles and the Contractor be the registered owner. The Contractor and/or a subcontractor may only use said vehicles for performance and under the terms of this Agreement.

(3) The Contractor and/or Subcontractor agree that all operators of motor vehicles, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, hold a valid State of California driver's license. In the event that ten or more passengers are to be transported in any one vehicle, the operator also hold a State of California Class B driver's license.

(4) If any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the Contractor and/or Subcontractor, as applicable, provide, maintain, and certify that, at a minimum, the following type and amount of automobile liability insurance is in effect during the term of this Agreement or any extension period during which any vehicle remains in the Contractor's and/or Subcontractor's possession:

Automobile Liability Insurance

(a) The Contractor, by signing this Agreement, hereby certifies that it possesses or will obtain automobile liability insurance in the amount of $1,000,000 per occurrence for bodily injury and property damage combined. Said insurance must be obtained and made effective upon the delivery date of any motor vehicle, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, to the Contractor and/or Subcontractor.

(b) The Contractor and/or Subcontractor, as soon as practical, furnish a copy of the certificate of insurance to the DHCS Program Contract Manager. The certificate of insurance identify the DHCS contract or agreement number for which the insurance applies.

(c) The C**o**ntractor and/or Subcontractor agree that bodily injury and property damage liability insurance, as required herein, remain in effect at all times during the term of this Agreement or until such time as the motor vehicle is

Back to Agenda Back to Item

returned to DHCS.

(d) The Contractor and/or Subcontractor agree to provide, at least thirty (30) days prior to the expiration date of said insurance coverage, a copy of a new certificate of insurance evidencing continued coverage, as indicated herein, for not less than the remainder of the term of this Agreement, the term of any extension or continuation thereof, or for a period of not less than one (1) year.

(e) The Contractor and/or Subcontractor, if not a self-insured government and/or public entity, must provide evidence, that any required certificates of insurance contain the following provisions:

[1] The insurer will not cancel the insured's coverage without giving thirty (30) calendar days prior written notice to the State (California Department of Health Care Services).

[2] The State of California, its officers, agents, employees, and servants are included as additional insureds, but only with respect to work performed for the State under this Agreement and any extension or continuation of this Agreement.

[3] The insurance carrier notify the California Department of Health Care Services (DHCS), in writing, of the Contractor's failure to pay premiums; its cancellation of such policies; or any other substantial change, including, but not limited to, the status, coverage, or scope of the required insurance. Such notices contain a reference to each agreement number for which the insurance was obtained.

(f) The Contractor and/or Subcontractor is hereby advised that copies of certificates of insurance may be subject to review and approval by the Department of General Services (DGS), Office of Risk and Insurance Management. The Contractor be notified by DHCS, in writing, if this provision is applicable to this Agreement. If DGS approval of the certificate of insurance is required, the Contractor agrees that no work or services shall be performed prior to obtaining said approval.

(g) In the event the Contractor and/or Subcontractor fails to keep insurance coverage, as required herein, in effect at all times during vehicle possession, DHCS may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

5. Subcontract Requirements

(Applicable to agreements under which services are to be performed by subcontractors including independent consultants.)

a. Prior written authorization will be required before the Contractor enters into or is reimbursed for any subcontract for services costing $5,000 or more. Except as indicated in Paragraph a(3) herein, when securing subcontracts for services exceeding $5,000, the Contractor obtain at least three bids or justify a sole source award.

   (1) The Contractor must provide in its request for authorization, all information necessary for evaluating the necessity or desirability of incurring such cost.

   (2) DHCS may identify the information needed to fulfill this requirement.

   (3) Subcontracts performed by the following entities or for the service types listed below are exempt from the bidding and sole source justification requirements:

      (a) A local governmental entity or the federal government,

      (b) A State college or State university from any State,

      (c) A Joint Powers Authority,

      (d) An auxiliary organization of a California State University or a California community college,

      (e) A foundation organized to support the Board of Governors of the California Community Colleges,

      (f) An auxiliary organization of the Student Aid Commission established under Education Code § 69522,

      (g) Firms or individuals proposed for use and approved by DHCS' funding Program via acceptance of an application or proposal for funding or pre/post contract award negotiations,

      (h) Entities and/or service types identified as exempt from advertising and competitive bidding in State Contracting Manual Chapter 5 Section 5.80 Subsection B.2.

b. DHCS reserves the right to approve or disapprove the selection of subcontractors and with advance written notice, require the substitution of subcontractors and require the Contractor to terminate subcontracts entered into in support of this Agreement.

   (1) Upon receipt of a written notice from DHCS requiring the substitution and/or termination of a subcontract, the Contractor take steps to ensure the completion of any work in progress and select a replacement, if applicable, within 30 calendar days, unless a longer period is agreed to by DHCS.

Back to Agenda Back to Item

c. Actual subcontracts (i.e., written agreement between the Contractor and a subcontractor) of $5,000 or more are subject to the prior review and written approval of DHCS. DHCS may, at its discretion, elect to waive this right. All such waivers be confirmed in writing by DHCS.

d. Contractor maintain a copy of each subcontract entered into in support of this Agreement and, upon request by DHCS, make copies available for approval, inspection, or audit.

e. DHCS assumes no responsibility for the payment of subcontractors used in the performance of this Agreement. Contractor accepts sole responsibility for the payment of subcontractors used in the performance of this Agreement.

f. The Contractor is responsible for all performance requirements under this Agreement even though performance may be carried out through a subcontract.

g. The Contractor ensure that all subcontracts for services include provision(s) requiring compliance with applicable terms and conditions specified in this Agreement.

h. The Contractor agrees to include the following clause, relevant to record retention, in all subcontracts for services:

"(Subcontractor Name) agrees to maintain and preserve, until three years after termination of (Agreement Number) and final payment from DHCS to the Contractor, to permit DHCS or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers and records related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records."

i. Unless otherwise stipulated in writing by DHCS, the Contractor be the subcontractor's sole point of contact for all matters related to performance and payment under this Agreement.

j. Contractor, as applicable, advise all subcontractors of their obligations pursuant to the following numbered provisions of this Exhibit: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 17, 19, 20, 24, 32 and/or other numbered provisions herein that are deemed applicable.

6. Income Restrictions

Unless otherwise stipulated in this Agreement, the Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this Agreement be paid by the Contractor to

DHCS, to the extent that they are properly allocable to costs for which the Contractor has been reimbursed by DHCS under this Agreement.

7. Audit and Record Retention

(Applicable to agreements in excess of $10,000.)

a. The Contractor and/or Subcontractor maintain books, records, documents, and other evidence, accounting procedures and practices, sufficient to properly reflect all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Agreement, including any matching costs and expenses. The foregoing constitutes "records" for the purpose of this provision.

b. The Contractor's and/or subcontractor's facility or office or such part thereof as may be engaged in the performance of this Agreement and his/her records be subject at all reasonable times to inspection, audit, and reproduction.

c. Contractor agrees that DHCS, the Department of General Services, the Bureau of State Audits, or their designated representatives including the Comptroller General of the United States have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, the Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement. (Government Code Section 8546.7, Public Contract Code (PCC) Sections 10115 et seq., Code of California Regulations Title 2, Section 1896.77.) The Contractor comply with the above and be aware of the penalties for violations of fraud and for obstruction of investigation as set forth in PCC Section10115.10.

d. The Contractor and/or Subcontractor preserve and make available his/her records (1) for a period of six years for all records related to Disabled Veteran Business Enterprise (DVBE) participation (Military and Veterans Code 999.55), if this Agreement involves DVBE participation, and three years for all other contract records from the date of final payment under this Agreement, and (2) for such longer period, if any, as is required by applicable statute, by any other provision of this Agreement, or by subparagraphs (1) or (2) below.

(1) If this Agreement is completely or partially terminated, the records relating to the work terminated be preserved and made available for a period of three years from the date of any resulting final settlement.

(2) If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the three-year period, the records be

retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three-year period, whichever is later.

e. The Contractor and/or Subcontractor may, at its discretion, following receipt of final payment under this Agreement, reduce its accounts, books and records related to this Agreement to microfilm, computer disk, CD ROM, DVD, or other data storage medium. Upon request by an authorized representative to inspect, audit or obtain copies of said records, the Contractor and/or Subcontractor must supply or make available applicable devices, hardware, and/or software necessary to view, copy and/or print said records. Applicable devices may include, but are not limited to, microfilm readers and microfilm printers, etc.

f. The Contractor, if applicable, comply with the Single Audit Act and the audit requirements set forth in 2 C.F.R. § 200.501 (2014).

8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract supported activities and the premises in which it is being performed. If any inspection or evaluation is made of the premises of the Contractor or Subcontractor, the Contractor provide and require Subcontractors to provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations be performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

(Applicable only to that portion of an agreement funded in part or whole with federal funds.)

a. It is mutually understood between the parties that this Agreement may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the Agreement were executed after that determination was made.

b. This agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or funding of this Agreement in any manner.

c. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this Agreement be amended to reflect any reduction in funds.

d. DHCS has the option to invalidate or cancel the Agreement with 30-days advance written notice or to amend the Agreement to reflect any reduction in funds.

10. Termination

a. **For Cause**

The State may terminate this Agreement, in whole or in part, and be relieved of any payments should the Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided. In the event of such termination, the State may proceed with the work in any manner deemed proper by the State. All costs to the State be deducted from any sum due the Contractor under this Agreement and the balance, if any, be paid to the Contractor upon demand. If this Agreement is terminated, in whole or in part, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials, related to the terminated portion of the Contract, including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The State pay contract price for completed deliverables delivered and accepted and items the State requires the Contractor to transfer as described in this paragraph above.

b. **For Convenience**

The State retains the option to terminate this Agreement, in whole or in part, without cause, at the State's convenience, without penalty, provided that written notice has been delivered to the Contractor at least ninety (90) calendar days prior to such termination date. In the event of termination, in whole or in part, under this paragraph, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials related to the terminated portion of the contract including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The Contractor will be entitled to compensation upon submission of an invoice and proper proof of claim for the services and products satisfactorily rendered, subject to all payment provisions of the Agreement. Payment is limited to expenses necessarily incurred pursuant to this Agreement up to the date of termination.

11. Intellectual Property Rights

a. **Ownership**

(1) Except where DHCS has agreed in a signed writing to accept a license, DHCS be and remain, without additional compensation, the sole owner of any and all rights, title and interest in all Intellectual Property, from the moment of creation, whether or not jointly conceived, that are made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

(2) For the purposes of this Agreement, Intellectual Property means recognized protectable rights and interest such as: patents, (whether or not issued) copyrights, trademarks, service marks, applications for any of the foregoing, inventions, trade secrets, trade dress, logos, insignia, color combinations, slogans, moral rights, right of publicity, author's rights, contract and licensing rights, works, mask works, industrial design rights, rights of priority, know how, design flows, methodologies, devices, business processes, developments, innovations, good will and all other legal rights protecting intangible proprietary information as may exist now and/or here after come into existence, and all renewals and extensions, regardless of whether those rights arise under the laws of the United States, or any other state, country or jurisdiction.

(a) For the purposes of the definition of Intellectual Property, "works" means all literary works, writings and printed matter including the medium by which they are recorded or reproduced, photographs, art work, pictorial and graphic representations and works of a similar nature, film, motion pictures, digital images, animation cells, and other audiovisual works including positives and negatives thereof, sound recordings, tapes, educational materials, interactive videos and any other materials or products created, produced, conceptualized and fixed in a tangible medium of expression. It includes preliminary and final products and any materials and information developed for the purposes of producing those final products. Works does not include articles submitted to peer review or reference journals or independent research projects.

(3) In the performance of this Agreement, Contractor will exercise and utilize certain of its Intellectual Property in existence prior to the effective date of this Agreement. In addition, under this Agreement, Contractor may access and utilize certain of DHCS' Intellectual Property in existence prior to the effective date of this Agreement. Except as otherwise set forth herein, Contractor not use any of DHCS' Intellectual Property now existing or hereafter existing for any purposes without the prior written permission of DHCS. Except as otherwise set forth herein, neither the

Contractor nor DHCS give any ownership interest in or rights to its Intellectual Property to the other Party. If during the term of this Agreement, Contractor accesses any third-party Intellectual Property that is licensed to DHCS, Contractor agrees to abide by all license and confidentiality restrictions applicable to DHCS in the third-party's license agreement.

(4) Contractor agrees to cooperate with DHCS in establishing or maintaining DHCS' exclusive rights in the Intellectual Property, and in assuring DHCS' sole rights against third parties with respect to the Intellectual Property. If the Contractor enters into any agreements or subcontracts with other parties in order to perform this Agreement, Contractor require the terms of the Agreement(s) to include all Intellectual Property provisions. Such terms must include, but are not limited to, the subcontractor assigning and agreeing to assign to DHCS all rights, title and interest in Intellectual Property made, conceived, derived from, or reduced to practice by the subcontractor, Contractor or DHCS and which result directly or indirectly from this Agreement or any subcontract.

(5) Contractor further agrees to assist and cooperate with DHCS in all reasonable respects, and execute all documents and, subject to reasonable availability, give testimony and take all further acts reasonably necessary to acquire, transfer, maintain, and enforce DHCS' Intellectual Property rights and interests.

b. **Retained Rights / License Rights**

(1) Except for Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, Contractor retain title to all of its Intellectual Property to the extent such Intellectual Property is in existence prior to the effective date of this Agreement. Contractor hereby grants to DHCS, without additional compensation, a permanent, non-exclusive, royalty free, paid-up, worldwide, irrevocable, perpetual, non-terminable license to use, reproduce, manufacture, sell, offer to sell, import, export, modify, publicly and privately display/perform, distribute, and dispose Contractor's Intellectual Property with the right to sublicense through multiple layers, for any purpose whatsoever, to the extent it is incorporated in the Intellectual Property resulting from this Agreement, unless Contractor assigns all rights, title and interest in the Intellectual Property as set forth herein.

(2) Nothing in this provision shall restrict, limit, or otherwise prevent Contractor from using any ideas, concepts, know-how, methodology or techniques related to its performance under this Agreement, provided that Contractor's use does not infringe the patent, copyright, trademark rights, license or other Intellectual Property rights of DHCS or third party, or result in a breach or

Back to Agenda Back to Item

default of any provisions of this Exhibit or result in a breach of any provisions of law relating to confidentiality.

c. **Copyright**

(1) Contractor agrees that for purposes of copyright law, all works [as defined in Paragraph a, subparagraph (2)(a) of this provision] of authorship made by or on behalf of Contractor in connection with Contractor's performance of this Agreement be deemed "works made for hire". Contractor further agrees that the work of each person utilized by Contractor in connection with the performance of this Agreement will be a "work made for hire," whether that person is an employee of Contractor or that person has entered into an agreement with Contractor to perform the work. Contractor enter into a written agreement with any such person that: (i) all work performed for Contractor be deemed a "work made for hire" under the Copyright Act and (ii) that person assign all right, title, and interest to DHCS to any work product made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

(2) All materials, including, but not limited to, visual works or text, reproduced or distributed pursuant to this Agreement that include Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, include DHCS' notice of copyright, which read in 3mm or larger typeface: "© [Enter Current Year e.g., 2010, etc.], California Department of Health Care Services. This material may not be reproduced or disseminated without prior written permission from the California Department of Health Care Services." This notice should be placed prominently on the materials and set apart from other matter on the page where it appears. Audio productions contain a similar audio notice of copyright.

d. **Patent Rights**

With respect to inventions made by Contractor in the performance of this Agreement, which did not result from research and development specifically included in the Agreement's scope of work, Contractor hereby grants to DHCS a license as described under Section b of this provision for devices or material incorporating, or made through the use of such inventions. If such inventions result from research and development work specifically included within the Agreement's scope of work, then Contractor agrees to assign to DHCS, without additional compensation, all its right, title and interest in and to such inventions and to assist DHCS in securing United States and foreign patents with respect thereto.

e. **Third-Party Intellectual Property**

Except as provided herein, Contractor agrees that its performance of this Agreement not be dependent upon or include any Intellectual Property of Contractor or third party without first: (i) obtaining DHCS' prior written approval; and (ii) granting to or obtaining for DHCS, without additional compensation, a license, as described in Section b of this provision, for any of Contractor's or third-party's Intellectual Property in existence prior to the effective date of this Agreement. If such a license upon these terms is unattainable, and DHCS determines that the Intellectual Property should be included in or is required for Contractor's performance of this Agreement, Contractor obtain a license under terms acceptable to DHCS.

f. **Warranties**

(1) Contractor represents and warrants that:

(a) It is free to enter into and fully perform this Agreement.

(b) It has secured and will secure all rights and licenses necessary for its performance of this Agreement.

(c) Neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is currently no actual or threatened claim by any such thirdparty based on an alleged violation of any such right by Contractor.

(d) Neither Contractor's performance nor any part of its performance will violate the right of privacy of, or constitute a libel or slander against any person or entity.

(e) It has secured and will secure all rights and licenses necessary for Intellectual Property including, but not limited to, consents, waivers or releases from all authors of music or performances used, and talent (radio, television and motion picture talent), owners of any interest in and to real estate, sites, locations, property or props that may be used or shown.

(f) It has not granted and not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to DHCS in this Agreement.

(g) It has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

(h) It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this Agreement.

(2) DHCS makes no warranty that the intellectual property resulting from this agreement does not infringe upon any patent, trademark, copyright or the like, now existing or subsequently issued.

g. **Intellectual Property Indemnity**

(1) Contractor indemnify, defend and hold harmless DHCS and its licensees and assignees, and its officers, directors, employees, agents, representatives, successors, and users of its products, ("Indemnitees") from and against all claims, actions, damages, losses, liabilities (or actions or proceedings with respect to any thereof), whether or not rightful, arising from any and all actions or claims by any third party or expenses related thereto (including, but not limited to, all legal expenses, court costs, and attorney's fees incurred in investigating, preparing, serving as a witness in, or defending against, any such claim, action, or proceeding, commenced or threatened) to which any of the Indemnitees may be subject, whether or not Contractor is a party to any pending or threatened litigation, which arise out of or are related to (i) the incorrectness or breach of any of the representations, warranties, covenants or agreements of Contractor pertaining to Intellectual Property; or (ii) any Intellectual Property infringement, or any other type of actual or alleged infringement claim, arising out of DHCS' use, reproduction, manufacture, sale, offer to sell, distribution, import, export, modification, public and private performance/display, license, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement. This indemnity obligation apply irrespective of whether the infringement claim is based on a patent, trademark or copyright registration that issued after the effective date of this Agreement. DHCS reserves the right to participate in and/or control, at Contractor's expense, any such infringement action brought against DHCS.

(2) Should any Intellectual Property licensed by the Contractor to DHCS under this Agreement become the subject of an Intellectual Property infringement claim, Contractor will exercise its authority reasonably and in good faith to

Back to Agenda Back to Item

preserve DHCS' right to use the licensed Intellectual Property in accordance with this Agreement at no expense to DHCS. DHCS have the right to monitor and appear through its own counsel (at Contractor's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for DHCS to continue using the licensed Intellectual Property; or, replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property. If such remedies are not reasonably available, DHCS be entitled to a refund of all monies paid under this Agreement, without restriction or limitation of any other rights and remedies available at law or in equity.

(3) Contractor agrees that damages alone would be inadequate to compensate DHCS for breach of any term of this Intellectual Property Exhibit by Contractor. Contractor acknowledges DHCS would suffer irreparable harm in the event of such breach and agrees DHCS be entitled to obtain equitable relief, including without limitation an injunction, from a court of competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

h. **Federal Funding**

In any agreement funded in whole or in part by the federal government, DHCS may acquire and maintain the Intellectual Property rights, title, and ownership, which results directly or indirectly from the Agreement; except as provided in 37 Code of Federal Regulations part 401.14; however, the federal government shall have a non-exclusive, nontransferable, irrevocable, paid-up license throughout the world to use, duplicate, or dispose of such Intellectual Property throughout the world in any manner for governmental purposes and to have and permit others to do so.

i. **Survival**

The provisions set forth herein shall survive any termination or expiration of this Agreement or any project schedule.

12. Air or Water Pollution Requirements

Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt by law.

a. Government contractors agree to comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act (42 USC 7606) section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations.

b. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C. 7401 et seq.), as amended, and the Clean Water Act (33 U.S.C. 1251 et seq.), as amended.

13. Prior Approval of Training Seminars, Workshops or Conferences

Contractor obtain prior DHCS approval of the location, costs, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar, workshop, or conference conducted pursuant to this Agreement and of any reimbursable publicity or educational materials to be made available for distribution. The Contractor acknowledge the support of the State whenever publicizing the work under this Agreement in any media. This provision does not apply to necessary staff meetings or training sessions held for the staff of the Contractor or Subcontractor to conduct routine business matters.

14. Confidentiality of Information

a. The Contractor and its employees, agents, or subcontractors protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to the Contractor, its employees, agents, or subcontractors as a result of services performed under this Agreement, except for statistical information not identifying any such person.

b. The Contractor and its employees, agents, or subcontractors not use such identifying information for any purpose other than carrying out the Contractor's obligations under this Agreement.

c. The Contractor and its employees, agents, or subcontractors promptly transmit to the DHCS Program Contract Manager all requests for disclosure of such identifying information not emanating from the client or person.

d. The Contractor not disclose, except as otherwise specifically permitted by this Agreement or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS Program Contract Manager, except if disclosure is required by State or federal law.

e. For purposes of this provision, identity include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

f. As deemed applicable by DHCS, this provision may be supplemented by additional terms and conditions covering personal health information (PHI) or

personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this Agreement or incorporated into this Agreement by reference.

15. Documents, Publications and Written Reports

(Applicable to agreements over $5,000 under which publications, written reports and documents are developed or produced. Government Code Section 7550.)

Any document, publication or written report (excluding progress reports, financial reports and normal contractual communications) prepared as a requirement of this Agreement contain, in a separate section preceding the main body of the document, the number and dollar amounts of all contracts or agreements and subcontracts relating to the preparation of such document or report, if the total cost for work by nonemployees of the State exceeds $5,000.

16. Dispute Resolution Process

a. A Contractor grievance exists whenever there is a dispute arising from DHCS' action in the administration of an agreement. If there is a dispute or grievance between the Contractor and DHCS, the Contractor must seek resolution using the procedure outlined below.

   (1) The Contractor should first informally discuss the problem with the DHCS Program Contract Manager. If the problem cannot be resolved informally, the Contractor direct its grievance together with any evidence, in writing, to the program Branch Chief. The grievance state the issues in dispute, the legal authority or other basis for the Contractor's position and the remedy sought. The Branch Chief render a decision within ten (10) Working Days after receipt of the written grievance from the Contractor. The Branch Chief respond in writing to the Contractor indicating the decision and reasons therefore. If the Contractor disagrees with the Branch Chief's decision, the Contractor may appeal to the second level.

   (2) When appealing to the second level, the Contractor must prepare an appeal indicating the reasons for disagreement with Branch Chief's decision. The Contractor must include with the appeal a copy of the Contractor's original statement of dispute along with any supporting evidence and a copy of the Branch Chief's decision. The appeal be addressed to the Deputy Director of the division in which the branch is organized within ten (10) Working Days from receipt of the Branch Chief's decision. The Deputy Director of the division in which the branch is organized or his/her designee meet with the Contractor to review the issues raised. A written decision signed by the Deputy Director of the division in which the branch is organized or his/her designee be directed to the Contractor within twenty (20) working days of receipt of the Contractor's second level appeal.

b. If the Contractor wishes to appeal the decision of the Deputy Director of the division in which the branch is organized or his/her designee, the Contractor follow the procedures set forth in Health and Safety Code Section 100171.

c. Unless otherwise stipulated in writing by DHCS, all dispute, grievance and/or appeal correspondence be directed to the DHCS Program Contract Manager.

d. There are organizational differences within DHCS' funding programs and the management levels identified in this dispute resolution provision may not apply in every contractual situation. When a grievance is received and organizational differences exist, the Contractor be notified in writing by the DHCS Program Contract Manager of the level, name, and/or title of the appropriate management official that is responsible for issuing a decision at a given level.

17. Financial and Compliance Audit Requirements

a. The definitions used in this provision are contained in Section 38040 of the Health and Safety Code, which by this reference is made a part hereof.

b. Direct service contract means a contract or agreement for services contained in local assistance or subvention programs or both (see Health and Safety [H&S] Code Section 38020). Direct service contracts do not include contracts, agreements, grants, or subventions to other governmental agencies or units of government nor contracts or agreements with regional centers or area agencies on aging (H&S Code Section 38030).

c. The Contractor, as indicated below, agrees to obtain one of the following audits:

(1) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040)*** and receives **$25,000 or more** from any State agency under a direct service contract or agreement; the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit. Said audit be conducted according to Generally Accepted Auditing Standards. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**

(2) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040)*** and receives **less than $25,000** per year from any State agency under a direct service contract or agreement, the Contractor agrees to obtain a biennial single, organization wide financial and compliance audit, unless there is evidence of fraud or other violation of State law in connection with this Agreement. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**

Back to Agenda Back to Item

(3) ***If the Contractor is a State or Local Government entity or Nonprofit organization*** and expends $750,000 or more in federal awards, the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit according to the requirements specified in 2 C.F.R. 200.501 entitled "Audit Requirements". An audit conducted pursuant to this provision will fulfill the audit requirements outlined in Paragraphs c(1) and c(2) above. The audit be completed by the end of the ninth month following the end of the audit period. The requirements of this provision apply if:

(a) The Contractor is a recipient expending federal awards received directly from federal awarding agencies, or

(b) The Contractor is a subrecipient expending federal awards received from a pass-through entity such as the State, County or community based organization.

(4) If the Contractor submits to DHCS a report of an audit other than a 2 C.F.R. 200.501audit, the Contractor must also submit a certification indicating the Contractor has not expended $750,000 or more in federal funds for the year covered by the audit report.

d. Two copies of the audit report be delivered to the DHCS program funding this Agreement. The audit report must identify the Contractor's legal name and the number assigned to this Agreement. The audit report be due within 30 days after the completion of the audit. Upon receipt of said audit report, the DHCS Program Contract Manager forward the audit report to DHCS' Audits and Investigations Unit if the audit report was submitted under Section 16.c(3), unless the audit report is from a City, County, or Special District within the State of California whereby the report will be retained by the funding program.

e. The cost of the audits described herein may be included in the funding for this Agreement up to the proportionate amount this Agreement represents of the Contractor's total revenue. The DHCS program funding this Agreement must provide advance written approval of the specific amount allowed for said audit expenses.

f. The State or its authorized designee, including the Bureau of State Audits, is responsible for conducting agreement performance audits which are not financial and compliance audits. Performance audits are defined by Generally Accepted Government Auditing Standards.

g. Nothing in this Agreement limits the State's responsibility or authority to enforce State law or regulations, procedures, or reporting requirements arising thereto.

h. Nothing in this provision limits the authority of the State to make audits of this Agreement, provided however, that if independent audits arranged for by the

Contractor meet Generally Accepted Governmental Auditing Standards, the State rely on those audits and any additional audit work and build upon the work already done.

i. The State may, at its option, direct its own auditors to perform either of the audits described above. The Contractor will be given advance written notification, if the State chooses to exercise its option to perform said audits.

j. The Contractor must include a clause in any agreement the Contractor enters into with the audit firm doing the single organization wide audit to provide access by the State or Federal Government to the working papers of the independent auditor who prepares the single organization wide audit for the Contractor.

k. Federal or State auditors have "expanded scope auditing" authority to conduct specific program audits during the same period in which a single organization wide audit is being performed, but the audit report has not been issued. The federal or State auditors review and have access to the current audit work being conducted and will not apply any testing or review procedures which have not been satisfied by previous audit work that has been completed.

   The term "expanded scope auditing" is applied and defined in the U.S. General Accounting Office (GAO) issued Standards for *Audit of Government Organizations, Programs, Activities and Functions*, better known as the "yellow book".

18. Human Subjects Use Requirements

(Applicable only to federally funded agreements/grants in which performance, directly or through a subcontract/subaward, includes any tests or examination of materials derived from the human body.)

By signing this Agreement, Contractor agrees that if any performance under this Agreement or any subcontract or subagreement includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed meet the requirements of 42 U.S.C. Section 263a (CLIA) and the regulations thereunder.

19. Novation Requirements

If the Contractor proposes any novation agreement, DHCS act upon the proposal within 60 days after receipt of the written proposal. DHCS may review and consider the proposal, consult and negotiate with the Contractor, and accept or reject all or part of the proposal. Acceptance or rejection of the proposal may be made orally within the 60-day period and confirmed in writing within five days of said decision.

Upon written acceptance of the proposal, DHCS will initiate an amendment to this Agreement to formally implement the approved proposal.

20. Debarment and Suspension Certification

(Applicable to all agreements funded in part or whole with federal funds.)

a. By signing this Agreement, the Contractor/Grantee agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 2 CFR Part 180, 2 CFR Part 376

b. By signing this Agreement, the Contractor certifies to the best of its knowledge and belief, that it and its principals:

(1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

(2) Have not within a three-year period preceding this application/proposal/agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State or local) violation of federal or State antitrust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any other offense indicating a lack of business integrity or business honesty that seriously affects its business honesty;

(3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in Paragraph b(2) herein; and

(4) Have not within a three-year period preceding this application/proposal/agreement had one or more public transactions (federal, State or local) terminated for cause or default.

(5) Have not, within a three-year period preceding this application/proposal/agreement, engaged in any of the violations listed under 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376.

(6) not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

(7) Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

c. If the Contractor is unable to certify to any of the statements in this certification, the Contractor submit an explanation to the DHCS Program Contract Manager.

d. The terms and definitions herein have the meanings set out in 2 CFR Part 180 as supplemented by 2 CFR Part 376.

e. If the Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this Agreement for cause or default.

21. Smoke-Free Workplace Certification

(Applicable to federally funded agreements/grants and subcontracts/subawards, that provide health, day care, early childhood development services, education or library services to children under 18 directly or through local governments.)

a. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed.

b. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.

c. By signing this Agreement, Contractor or Grantee certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

d. Contractor or Grantee further agrees that it will insert this certification into any subawards (subcontracts or subgrants) entered into that provide for children's services as described in the Act.

22. Drug Free Workplace Act of 1988

The Federal government implemented the Drug Free Workplace Act of 1988 in an attempt to address the problems of drug abuse on the job. It is a fact that employees who use drugs have less productivity, a lower quality of work, and a higher absenteeism, and are more likely to misappropriate funds or services. From this perspective, the drug abuser may endanger other employees, the public at large, or themselves. Damage to property, whether owned by this entity or not, could result from drug abuse on the job. All these actions might undermine public confidence in the services this entity provides. Therefore, in order to remain a responsible source for government contracts, the following guidelines have been adopted:

a. The unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited in the work place.

b. Violators may be terminated or requested to seek counseling from an approved rehabilitation service.

c. Employees must notify their employer of any conviction of a criminal drug statue no later than five days after such conviction.

d. Although alcohol is not a controlled substance, it is nonetheless a drug. It is the policy that abuse of this drug will also not be tolerated in the workplace.

e. Contractors of federal agencies are required to certify that they will provide drug-free workplaces for their employees.

23. Covenant Against Contingent Fees

(Applicable only to federally funded agreements.)

The Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this Agreement upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by the Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS have the right to annul this Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

24. Payment Withholds

(Applicable only if a final report is required by this Agreement. Not applicable to government entities.)

Unless waived or otherwise stipulated in this Agreement, DHCS may, at its discretion, withhold 10 percent (10%) of the face amount of the Agreement, 50 percent (50%) of the final invoice, or $3,000 whichever is greater, until DHCS receives a final report that meets the terms, conditions and/or scope of work requirements of this Agreement.

25. Performance Evaluation

(Not applicable to grant agreements.)

DHCS may, at its discretion, evaluate the performance of the Contractor at the conclusion of this Agreement. If performance is evaluated, the evaluation not be a public record and remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

26. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this Agreement, or to any benefit that may arise therefrom. This provision shall not be construed to extend to this Agreement if made with a corporation for its general benefits.

27. Four-Digit Date Compliance

(Applicable to agreements in which Information Technology (IT) services are provided to DHCS or if IT equipment is procured.)

Contractor warrants that it will provide only Four-Digit Date Compliant (as defined below) Deliverables and/or services to the State. “Four Digit Date compliant” Deliverables and services can accurately process, calculate, compare, and sequence date data, including without limitation date data arising out of or relating to leap years and changes in centuries. This warranty and representation is subject to the warranty terms and conditions of this Contract and does not limit the generality of warranty obligations set forth elsewhere herein.

28. Prohibited Use of State Funds for Software

(Applicable to agreements in which computer software is used in performance of the work.)

Contractor certifies that it has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

29. Use of Disabled Veteran's Business Enterprises (DVBE)

(Applicable to agreements over $10,000 in which the Contractor committed to achieve DVBE participation. Not applicable to agreements and amendments specifically exempted from DVBE requirements by DHCS.)

a. The State Legislature has declared that a fair portion of the total purchases and contracts or subcontracts for property and services for the State be placed with disabled veteran business enterprises.

b. All DVBE participation attachments, however labeled, completed as a condition of bidding, contracting, or amending a subject agreement, are incorporated herein and made a part of this Agreement by this reference.

c. Contractor agrees to use the proposed DVBEs, as identified in previously submitted DVBE participation attachments. Contractor understands and agrees to comply with the requirements set forth in Military and Veterans Code Section 999 et seq. in that should award of this contract be based on part on its commitment to use the DVBE subcontractor(s) identified in its bid or offer, per Military and Veterans Code section 999.5(g), a DVBE subcontractor may only be replaced by another DVBE subcontractor and must be approved by both DHCS and the Department of General Services (DGS) prior to the commencement of any work by the proposed subcontractor. Changes to the scope of work that impact the DVBE subcontractor(s) identified in the bid or offer and approved DVBE substitutions will be documented by contract amendment.

d. Requests for DVBE subcontractor substitution must include:

   (1) A written explanation of the reason for the DVBE substitution.

   (2) A written description of the business enterprise that will be substituted, including its DVBE certification status.

   (3) A written description of the work to be performed by the substituted DVBE subcontractor and an identification of the percentage share/dollar amount of the overall contract that the substituted subcontractor will perform.

e. Failure of the Contractor to seek substitution and adhere to the DVBE participation level identified in the bid or offer may be cause for contract termination, recovery of damages under rights and remedies due to the State, and penalties as outlined in Military and Veterans Code § 999.9; Public Contract Code (PCC) §10115.10, or PCC §4110 (applies to public works only).

f. Upon completion of this Contract, DHCS requires the Contractor to certify using the Prime Contractor's Certification – DVBE Subcontracting Report (STD 817), al of the following: -

(1) The total amount the prime contractor received under the agreement;

(2) The name, address, Contract number and certification ID Number of the DVBE(s) that participated in the performance of this Contract;

(3) The amount and percentage of work the prime Contractor committed to provide to one or more DVBE(s) under the requirements of the Contract and the total payment each DVBE received from the prime Contractor;;

(4) That all payments under the Contract have been made to the DVBE(s); and

(5) The actual percentage of DVBE participation that was achieved. Upon request, the prime Contractor must provide proof of payment for the work.

g. If for this Contract the Contractor made a commitment to achieve the DVBE participation goal, DHCS will withhold $10,000 from the final payment, or the full payment if less than $10,000, until the Contractor complies with the certification requirements above. A Contractor that fails to comply with the certification requirement must, after written notice, be allowed to cure the defect. Notwithstanding any other law, if, after at least 15 calendar days but not more than 30 calendar days from the date of written notice, the prime Contractor refuses to comply with the certification requirements, DHCS will permanently deduct $10,000 from the final payment, or the full payment if less than $10,000. (Mil. & Vet. Code § 999.7.)

h. A person or entity that knowingly provides false information will be subject to a civil penalty for each violation. (Mil. & Vet. Code § 999.5(d); Govt. Code § 14841.)

i. Contractor agrees to comply with the rules, regulations, ordinances, and statutes that apply to the DVBE program as defined in Section 999 of the Military & Veterans Code, including, but not limited to, the requirements of Section 999.5(d). (PCC§ 10230.)

30. Use of Small, Minority Owned and Women's Businesses

(Applicable to that portion of an agreement that is federally funded and entered into with institutions of higher education, hospitals, nonprofit organizations or commercial businesses.)

Positive efforts be made to use small businesses, minority-owned firms and women's business enterprises, whenever possible (i.e., procurement of goods and/or services). Contractors take all of the following steps to further this goal.

a. Ensure that small businesses, minority-owned firms, and women's business enterprises are used to the fullest extent practicable.

b. Make information on forthcoming purchasing and contracting opportunities available and arrange time frames for purchases and contracts to encourage and facilitate participation by small businesses, minority-owned firms, and women's business enterprises.

c. Consider in the contract process whether firms competing for larger contracts intend to subcontract with small businesses, minority-owned firms, and women's business enterprises.

d. Encourage contracting with consortiums of small businesses, minority-owned firms and women's business enterprises when a contract is too large for one of these firms to handle individually.

e. Use the services and assistance, as appropriate, of such organizations as the Federal Small Business Administration and the U.S. Department of Commerce's Minority Business Development Agency in the solicitation and utilization of small businesses, minority-owned firms and women's business enterprises.

31. Alien Ineligibility Certification

(Applicable to sole proprietors entering federally funded agreements.)

By signing this Agreement, the Contractor certifies that he/she is not an alien that is ineligible for State and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 U.S.C. 1601, et seq.)

32. Union Organizing

(Applicable only to grant agreements.)

Grantee, by signing this Agreement, hereby acknowledges the applicability of Government Code Sections 16645 through 16649 to this Agreement. Furthermore, Grantee, by signing this Agreement, hereby certifies that:

a. No State funds disbursed by this grant will be used to assist, promote or deter union organizing.

b. Grantee account for State funds disbursed for a specific expenditure by this grant, to show those funds were allocated to that expenditure.

c. Grantee, where State funds are not designated as described in b herein, allocate, on a pro-rata basis, all disbursements that support the grant program.

d. If Grantee makes expenditures to assist, promote or deter union organizing, Grantee will maintain records sufficient to show that no State funds were used for those expenditures, and that Grantee provide those records to the Attorney General upon request.

33. Contract Uniformity (Fringe Benefit Allowability)

(Applicable only to nonprofit organizations.)

Pursuant to the provisions of Article 7 (commencing with Section 100525) of Chapter 3 of Part 1 of Division 101 of the Health and Safety Code, DHCS sets forth the following policies, procedures, and guidelines regarding the reimbursement of fringe benefits.

a. As used herein fringe benefits shall mean an employment benefit given by one's employer to an employee in addition to one's regular or normal wages or salary.

b. As used herein, fringe benefits do not include:

(1) Compensation for personal services paid currently or accrued by the Contractor for services of employees rendered during the term of this Agreement, which is identified as regular or normal salaries and wages, annual leave, vacation, sick leave, holidays, jury duty and/or military leave/training.

(2) Director's and executive committee member's fees.

(3) Incentive awards and/or bonus incentive pay.

(4) Allowances for off-site pay.

(5) Location allowances.

(6) Hardship pay.

(7) Cost-of-living differentials

c. Specific allowable fringe benefits include:

(1) Fringe benefits in the form of employer contributions for the employer's portion of payroll taxes (i.e., FICA, SUI, SDI), employee health plans (i.e., health, dental and vision), unemployment insurance, worker's compensation insurance, and the employer's share of pension/retirement plans, provided they are granted in accordance with established written organization policies and meet all legal and Internal Revenue Service requirements.

d. To be an allowable fringe benefit, the cost must meet the following criteria:

(1) Be necessary and reasonable for the performance of the Agreement.

(2) Be determined in accordance with generally accepted accounting principles.

(3) Be consistent with policies that apply uniformly to all activities of the Contractor.

e. Contractor agrees that all fringe benefits be at actual cost.

f. Earned/Accrued Compensation

(1) Compensation for vacation, sick leave and holidays is limited to that amount earned/accrued within the agreement term. Unused vacation, sick leave and holidays earned from periods prior to the agreement term cannot be claimed as allowable costs. See Provision f (3)(a) for an example.

(2) For multiple year agreements, vacation and sick leave compensation, which is earned/accrued but not paid, due to employee(s) not taking time off may be carried over and claimed within the overall term of the multiple years of the Agreement. Holidays cannot be carried over from one agreement year to the next. See Provision f (3)(b) for an example.

(3) For single year agreements, vacation, sick leave and holiday compensation that is earned/accrued but not paid, due to employee(s) not taking time off within the term of the Agreement, cannot be claimed as an allowable cost. See Provision f (3)(c) for an example.

(a) **Example No. 1:**

If an employee, John Doe, earns/accrues three weeks of vacation and twelve days of sick leave each year, then that is the maximum amount that may be claimed during a one year agreement. If John Doe has five weeks of vacation and eighteen days of sick leave at the beginning of an agreement, the Contractor during a one-year budget period may only claim up to three weeks of vacation and twelve days of sick leave as actually used by the employee. Amounts earned/accrued in periods prior to the beginning of the Agreement are not an allowable cost.

(b) **Example No. 2:**

If during a three-year (multiple year) agreement, John Doe does not use his three weeks of vacation in year one, or his three weeks in year two, but he does actually use nine weeks in year three; the Contractor would be allowed to claim all nine weeks paid for in year three. The total compensation over the three-year period cannot exceed 156 weeks (3 x 52 weeks).

(c) **Example No. 3:**

If during a single year agreement, John Doe works fifty weeks and used one week of vacation and one week of sick leave and all fifty-two weeks have been billed to DHCS, the remaining unused two weeks of vacation and seven days of sick leave may not be claimed as an allowable cost.

34. Suspension or Stop Work Notification

a. DHCS may, at any time, issue a notice to suspend performance or stop work under this Agreement. The initial notification may be a verbal or written directive issued by the funding Program's Contract Manager. Upon receipt of said notice, the Contractor is to suspend and/or stop all, or any part, of the work called for by this Agreement.

b. Written confirmation of the suspension or stop work notification with directions as to what work (if not all) is to be suspended and how to proceed will be provided within 30 Working Days of the verbal notification. The suspension or stop work notification remain in effect until further written notice is received from DHCS. The resumption of work (in whole or part) will be at DHCS' discretion and upon receipt of written confirmation.

(1) Upon receipt of a suspension or stop work notification, the Contractor immediately comply with its terms and take all reasonable steps to minimize or halt the incurrence of costs allocable to the performance covered by the notification during the period of work suspension or stoppage.

(2) Within 90 days of the issuance of a suspension or stop work notification, DHCS either:

(a) Cancel, extend, or modify the suspension or stop work notification; or

(b) Terminate the Agreement as provided for in the Cancellation / Termination clause of the Agreement.

c. If a suspension or stop work notification issued under this clause is canceled or the period of suspension or any extension thereof is modified or expires, the Contractor may resume work only upon written concurrence of funding Program's Contract Manager.

d. If the suspension or stop work notification is cancelled and the Agreement resumes, changes to the services, deliverables, performance dates, and/or contract terms resulting from the suspension or stop work notification shall require an amendment to the Agreement.

e. If a suspension or stop work notification is not canceled and the Agreement is cancelled or terminated pursuant to the provision entitled Cancellation /

Termination, DHCS allow reasonable costs resulting from the suspension or stop work notification in arriving at the settlement costs.

f. DHCS shall not be liable to the Contractor for loss of profits because of any suspension or stop work notification issued under this clause.

35. Public Communications

"Electronic and printed documents developed and produced, for public communications follow the following requirements to comply with Section 508 of the Rehabilitation Act and the American with Disabilities Act:

a. Ensure visual-impaired, hearing-impaired and other special needs audiences are provided material information in formats that provide the most assistance in making informed choices."

36. Compliance with Statutes and Regulations

a. The Contractor must comply with all California and federal law, regulations, and published guidelines, to the extent that these authorities contain requirements applicable to Contractor's performance under the Agreement.

b. These authorities include, but are not limited to, Title 2, Code of Federal Regulations (CFR) Part 200, subpart F, Appendix II; Title 42 CFR Part 431, subpart F; Title 42 CFR Part 433, subpart D; Title 42 CFR Part 434; Title 45 CFR Part 75, subpart D; and Title 45 CFR Part 95, subpart F. To the extent applicable under federal law, this Agreement incorporate the contractual provisions in these federal regulations and they supersede any conflicting provisions in this Agreement.

37. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded agreements in excess of $100,000 per Section 1352 of the 31, U.S.C.)

a. Certification and Disclosure Requirements

(1) Each person (or recipient) who requests or receives a contract or agreement, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, file a certification (in the form set forth in Attachment 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph b of this provision.

(2) Each recipient file a disclosure (in the form set forth in Attachment 2, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has

made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract, or grant or any extension or amendment of that contract, or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

(3) Each recipient file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph a(2) herein. An event that materially affects the accuracy of the information reported includes:

(a) A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

(b) A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

(c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

(4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract or agreement, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or agreement, or grant file a certification, and a disclosure form, if required, to the next tier above.

(5) All disclosure forms (but not certifications) be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person forward all disclosure forms to DHCS Program Contract Manager.

b. Prohibition

Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract or agreement, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract or agreement, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract or agreement, grant, loan, or cooperative agreement.

Back to Agenda Back to Item

Attachment 1
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this federal contract, federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this federal contract, grant, or cooperative agreement.

2. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, or cooperative agreement, the undersigned complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

3. The undersigned require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

California Department of Health Care Services

DHCS reserves the right to notifiy the contractor in writing of an alternate submission address.

Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB (0348-0046)

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
_ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	_ a. bid/offer/application b. initial award c. post-award	_ a. initial filing b. material change For Material Change Only: Year ___ quarter date of last report ___.

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
☐Prime ☐Subawardee Tier __, if known: Congressional District, If known:	Congressional District, If known:
6. Federal Department/Agency	7. Federal Program Name/Description:
	CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10.a. Name and Address of Lobbying Registrant *(If individual, last name, first name, MI)*:	b. Individuals Performing Services *(including address if different from 10a. (Last name, First name, MI):*

Back to Agenda Back to Item

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person that fails to file the required disclosure shall be subject to a not more than $100,000 for each such failure.	
Signature:	
Print Name:	
Title:	
Telephone Number:	
Date:	
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form be completed by the reporting entity, whether subawardee or prime federal recipient, at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if itis, or expects to be,a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, state and zip code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001".

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).

11. The certifying official sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

Exhibit E – Program Terms and Conditions

1.0 Program Terms and Conditions

1.1 Program Terms and Conditions

1.1.1 Governing Law
1.1.2 DHCS Guidance
1.1.3 Contract Interpretation
1.1.4 Assignments, Mergers, Acquisitions
1.1.5 Independent Contractor
1.1.6 Amendment and Change Order Process
1.1.7 Delegation of Authority
1.1.8 Authority of the State
1.1.9 Fulfillment of Obligations
1.1.10 Obtaining DHCS Approval
1.1.11 Certifications
1.1.12 Notices
1.1.13 Term
1.1.14 Service Area
1.1.15 Contract Extension
1.1.16 Termination
1.1.17 Phaseout Requirements
1.1.18 Indemnification
1.1.19 Sanctions
1.1.20 Liquidated Damages
1.1.21 Contractor's Dispute Resolution Requirements
1.1.22 Inspection and Audit of Records and Facilities
1.1.23 Confidentiality of Information
1.1.24 Pilot Projects
1.1.25 Cost Avoidance and Post-Payment Recovery of Other Health Coverage
1.1.26 Third-Party Tort and Workers' Compensation Liability
1.1.27 Litigation Support
1.1.28 Equal Opportunity Employer
1.1.29 Federal and State Nondiscrimination Requirements
1.1.30 Discrimination Prohibitions
1.1.31 Small Business Participation and Disabled Veteran Business Enterprises Reporting Requirements
1.1.32 Conflict of Interest Avoidance Requirements
1.1.33 Guaranty Provision
1.1.34 Priority of Provisions
1.1.35 Additional Incorporated Provisions – Narrative Proposals
1.1.36 Miscellaneous Provisions
1.1.37 Data Sharing

Back to Agenda Back to Item

Exhibit E - Program Terms and Conditions

1.1.1 Governing Law

A. Contractor must comply with all applicable federal and State law.

B. All Contract disputes and determinations must be decided under California law.

C. The venue and forum for any action involving a Contract dispute will be in the Superior Court for the State of California, County of Sacramento.

D. Applicability of the Knox-Keene Act

1) A Contractor who is licensed as a health care service plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (KKA) (and its implementing regulations (28 California Code of Regulations (CCR) section 1000, *et seq*.) must comply with all applicable provisions of the KKA.

2) A Contractor who is not licensed to operate as a health care service plan pursuant to the KKA must perform all acts and satisfy all requirements under the KKA to the same extent as Contractors who are licensed pursuant to the KKA, except as otherwise expressly provided in this Contract. A Contractor who is not licensed to operate as a health care service plan under the KKA is not required by this Contract to perform or satisfy the following:

a) Any provision of the KKA which requires the submission of a report of any kind to the Department of Managed Health Care (DMHC) or obliges a health care service plan to seek approval from DMHC, including, but not limited to, the Independent Medical Review processes set out in section 1370.4 and Article 5.55 of the KKA;

b) Any provision under Article 3 of the KKA related to licensure; and

c) The provisions set forth in Exhibit K of this Contract. Exhibit K is not an exhaustive or exclusive list, and other provisions of the KKA may also be excluded from the Contract pursuant to this Exhibit E, Subsection 1.1.1 (*Governing Law*) or other provisions of this Contract.

3) Both KKA-licensed Contractors and non-KKA-licensed Contractors are subject to the following provisions:

   a) Nothing in this Exhibit E, Subsection 1.1.1 (*Governing Law*) is intended to relieve Contractor of any other duties or requirements that would otherwise apply; and

   b) In the event that a provision of this Contract sets a standard or requirement that is higher, or affords a greater benefit or right to a Member than that which the KKA provides, the Contract provisions prevail.

1.1.2 DHCS Guidance

Contractor must comply with all DHCS guidance, including but not limited to All Plan Letters (APLs), PLs, the California Medicaid State Plan, and the Medi-Cal Provider Manual.

A. APLs and PLs

Contractor must comply with all existing and future APLs and PLs as follows:

1) APLs and PLs existing on the effective date of the Contract will be considered part of the Contract as if fully set forth herein;

2) APLs and PLs issued or revised subsequent to the effective date of the Contract can provide clarification of existing contractual obligations;

3) APLs and PLs issued or revised subsequent to the effective date of the Contract can provide instructions regarding implementation of mandated obligations, including but not limited to implementation of changes in State or federal statutes or regulations, or pursuant to judicial interpretation; and

4) APLs and PLs issued by DHCS pursuant to statutory authority to issue guidance in lieu of regulations will have the same force and effect as regulations and may set forth new obligations.

5) APLs and PLs cited and incorporated by reference into the Contract also include any subsequent revisions to the APL or PL.

B. California Medicaid State Plan

Unless otherwise specified in this Contract, Contractor will comply with all applicable provisions of the California Medicaid State Plan, as amended. In the event there is a conflict between the California Medicaid State Plan and this Contract, the California Medicaid State Plan will control. The California Medicaid State Plan and any amendments thereto, can be viewed at the California's Medicaid State Plan (Title XIX) web page.

C. Medi-Cal Provider Manual

Unless otherwise specified in this Contract, Contractor must comply with all current and applicable provisions of the Medi-Cal Provider Manual. In the event that the Medi-Cal Provider Manual conflicts with this Contract, APLs and PLs, and/or any applicable federal or State laws, the Contract, the APL or PL, or the applicable law will control. The Medi-Cal Provider Manual can be viewed online.

1.1.3 Contract Interpretation

A. Conflict with Law

Any provision of this Contract that is in conflict with current or future applicable federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract will be effective on the effective date of the statutes or regulations necessitating it and will be binding on Contractor even though such amendment may not yet have been put in writing, formally agreed upon, and executed by Contractor and DHCS.

If changes in federal or State law result in a material change to the Contract, the amendment may constitute grounds for termination of this Contract in accordance with Exhibit E, Subsection 1.1.16 (*Termination*). The parties will be bound by the terms of the amendment until the effective date of the termination.

B. Word Usage

Unless the context of this Contract clearly requires otherwise, (a) the plural and singular numbers will each be deemed to include the other; (b) the masculine, feminine, and neuter genders will each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

C. Ambiguities

If it is necessary to interpret the text of this Contract to address potential ambiguities, all applicable laws may be used as aids in interpreting the Contract. However, DHCS and Contractor agree that any such applicable laws will not be interpreted to create additional contractual obligations upon either DHCS or Contractor, unless such applicable laws are expressly incorporated into this Contract in some section other than this Section. This Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Contract, both parties will be deemed authors of this Contract.

D. Unenforceable Provisions

In the event that any provision of this Contract is unenforceable or held to be unenforceable, then DHCS and Contractor agree that all other provisions of this Contract have force and effect and will not be affected thereby.

E. Timeliness

Time is of the essence in this Contract.

F. Entire Agreement

This written Contract, any amendments thereto, and DHCS guidance as identified in Exhibit E, Subsection 1.1.2 (*DHCS Guidance*), will constitute the entire agreement between the parties. No oral representations will be binding on either party unless such representations are put in writing and made an amendment to this Contract.

1.1.4 Assignments, Mergers, Acquisitions

Contractor is prohibited from assigning this Contract, either in whole or in part, without the express written consent of DHCS in the form of a formal written amendment signed by DHCS, Contractor, and the third-party assignee (See also, Exhibit A, Attachment III, Subsection 3.1.2 (*DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements).* Contractor must also obtain the express written consent of DHCS prior to entering into a merger or acquisition, whether or not Contractor is the merging party or the acquiring party.

1.1.5 Independent Contractor

Contractor and their employees and agents, in the performance of this Contract, will act in an independent capacity and not as officers or employees or agents of DHCS.

1.1.6 Amendment and Change Order Process

A. General Provisions

The parties recognize that during the term of this Contract, the Medi-Cal managed care program is a dynamic program requiring ongoing changes to its operations and that the scope and complexity of changes will vary widely over the term of this Contract. Contractor must develop a system which has the capability to implement such changes in an orderly and timely manner. This is an essential contract performance obligation.

B. Proposal of Contract Changes

Except for required amendments pursuant to Exhibit E, Subsection 1.1.3.A (*Contract Interpretation*) should either party, during the life of this Contract, desire a change in this Contract, that change must be proposed in writing to the other party. The other party must acknowledge receipt of the proposal within ten calendar days of receipt of the proposal. The party proposing any such change will have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal must set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract.

1) Regardless of the party desiring the change, DHCS will be responsible for drafting the proposed amendment and providing it to Contractor for review and comment prior to the language being finalized and submitted to CMS for approval.

2) DHCS will determine Contractor's Capitation Payment rates for each Rating Period and, as necessary, subsequent revised rates for the same Rating Period, as stated in Exhibit B, Subsection 1.1.5 (*Determination and Redetermination of Capitation Payment Rates*).

C. Implementation of Contract Capitation Payments

DHCS may, at any time within the general scope of this Contract and by written notice, implement Capitation Payment rates through amendments

Back to Agenda Back to Item

to the Contract upon approval from CMS. Capitation Payment rates that are tied to proposed changes to the terms or requirements of the Contract effective within the Rating Period will be included in an amendment to the Contract.

D. Contractor's Obligation to Implement

Notwithstanding approval by CMS of proposed changes to this Contract, Contractor will comply with changes mandated by DHCS. In the case of changes mandated by regulations, statutes, federal guidelines, or judicial interpretation, Contractor must immediately begin implementation of any change proposed in an amendment to this Contract or through an APL. If DHCS implements an amendment or APL, Contractor must implement the required changes and accept current Capitation Payments as stated in Exhibit B, Section 1.5 (*Determination and Redetermination of Capitation Payment Rates*) while discussions relevant to any Capitation Payment rate adjustment, if applicable, are taking place.

1.1.7 Delegation of Authority

DHCS intends to implement this Contract through a single administrator, called the "DHCS Contracting Officer." The Director will appoint its DHCS Contracting Officer. The DHCS Contracting Officer, under the direction of the Director and on behalf of DHCS, will make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable federal and State laws and regulations. The DHCS Contracting Officer may delegate their authority to act to an authorized representative through written notice to Contractor.

Contractor will designate a single administrator (Contractor's Representative) to implement this Contract. Contractor's Representative, on behalf of Contractor, will make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of the Contract, federal and State laws and regulations. Contractor's Representative may delegate their authority to act to an AR through written notice to the DHCS Contracting Officer. Contractor's Representative will be empowered to legally bind Contractor to all agreements reached with DHCS.

Contractor will designate Contractor’s Representative in writing and must notify the DHCS Contracting Officer in accordance with Exhibit E, Subsection 1.1.12 (*Notices*).

1.1.8 Authority of the State

A. Subject to federal and State laws and regulations, DHCS has sole authority to establish, define, and determine the reasonableness, necessity, level, and scope of Covered Services available under the Medi-Cal managed care program administered through this Contract or coverage for such benefits, or the eligibility of Members or Providers to participate in the Medi-Cal managed care program.

B. DHCS has sole authority to establish or interpret policy and its application related to administration of the Medi-Cal program.

C. Contractor must not make any limitations, exclusions, or changes in benefits or benefit coverage; any changes in definition or interpretation of benefits; or any changes in the administration of the Contract related to the scope of benefits, allowable coverage for those benefits; or eligibility of Members or Providers to participate in the program, without the express, written direction or approval of the DHCS Contracting Officer.

1.1.9 Fulfillment of Obligations

Contractor must not waive any covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract except by written agreement of the parties. Forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply. Until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party will have the right to invoke any remedy available under this Contract, or under law, notwithstanding such forbearance or indulgence.

1.1.10 Obtaining DHCS Approval

A. DHCS Approval of Deliverables Prior to Commencement of Operations

Prior to commencement of operations, Contractor must obtain written approval from DHCS for all deliverables, including but not limited to protocols, policies, and procedures, set forth in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*).

B. DHCS Approval of Protocols, Policies, and Procedures

In addition to the deliverables identified in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) of this Contract, DHCS

Back to Agenda Back to Item

reserves the right to review and approve or disapprove Contractor's protocols, policies, and procedures. DHCS may, from time to time, request changes to Contractor's existing protocols, policies, and procedures. DHCS will issue such requests through APLs or other similar instructions. The deliverables, protocols, policies, and procedures referenced in this Exhibit E, Subsections 1.1.10.A and B (*Obtaining DHCS Approval*), will be subject to the DHCS approval process set forth in Exhibit E, Subsection 1.1.10.C (*Obtaining DHCS Approval*), below.

C. DHCS Approval Process

Within 60 calendar days of receipt, DHCS will make all reasonable efforts to approve in writing Contractor's deliverables, protocols, policies, and procedures; provide Contractor with a written explanation of disapproval; or provide a written estimated date of completion of DHCS' review process.

If DHCS does not complete its review of submitted materials within 60 calendar days of receipt, or within the estimated date of completion of DHCS review, Contractor may elect to implement or use the materials at Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This Exhibit E, Subsection 1.1.10.C (*Obtaining DHCS Approval*) will not be construed to imply DHCS approval of any materials that have not received written DHCS approval. This Section will not apply to Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements subject to DHCS approval in accordance with Exhibit A, Attachment III, Subsection 3.1.2 (*DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*).

1.1.11 Certifications

A. For each data submission required by 42 Code of Federal Regulations (CFR) section 438.604, Contractor must comply with the requirements of 42 CFR section 438.606 and APL 17-005. Contractor must submit its certification of compliance concurrently with the submission of its data, documentation or information pursuant to 42 CFR section 438.606(c). Contractor's certification(s) must be certified by Contractor's Chief Executive Officer (CEO); Chief Financial Officer (CFO); or an individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO. Contractor's CEO or CFO is solely responsible for the truth, accuracy and completeness of Contractor's certification.

Back to Agenda Back to Item

1) Contractor's data submissions must be in a form and manner specified by DHCS:

   a) Encounter Data as set forth in 42 CFR section 438.604(a)(1); and

   b) Data used by the State to certify actuarial soundness of Capitation Payment rates as set forth in 42 CFR section 438.604(a)(2).

2) Medical Loss Ratio (MLR) data as set forth in 42 CFR section 438.604(a)(3);

3) Financial data regarding provisions against risk of insolvency as set forth in 42 CFR section 438.604(a)(4);

4) Documentation described in 42 CFR section 438.207(b) used to certify compliance with this Contract's requirements for accessibility and availability of services, including Network adequacy;

5) Contractor's information on ownership and control, including its Subcontractors, Downstream Subcontractors, and Network Providers, as set forth in 42 CFR sections 438.608(c)(2), 438.602(c), and 455.104;

6) The annual report of overpayment recoveries as required in 42 CFR section 438.608(d)(3);

7) Network Data as required in Exhibit A, Attachment III, Subsection 2.1.4 (*Network Provider Data Reporting*);

8) Documentation confirming compliance with this Contract's interoperability requirements and APL 22-026 that is certified by Contractor's CEO or CFO and in accordance with submission requirements in APL 17-005; and

9) Any other data, documentation, or information requested by DHCS relating to the performance of Contractor's obligations under this Contract.

B. The Contractor Certification Clauses (CCC) contained in the Department of General Services form document CCC 04/2017 are hereby incorporated by reference and made a part of this Contract by this reference as if attached hereto.

Back to Agenda Back to Item

1.1.12 Notices

All notices to be given under this Contract must be in writing and are deemed given when sent certified mailed or electronic mail (email) to DHCS or Contractor. DHCS and Contractor will designate email addresses for notices sent via email. Notices sent certified mail must be addressed to the following DHCS and Contractor addresses:

California Department of Health Care Services
Managed Care Operations Division

Attn: DHCS Contract Manager
MS 4407
P.O. Box 997413
Sacramento, CA 95899-7413

Orange County Health Authority, A Public Agency
dba CalOptima Health
Attn: Contractor Representative
505 City Parkway West
Orange, CA 92868

1.1.13 Term

A. The Contract will be effective January 1, 2024, and will continue in full force and effect through December 31, 2025, subject to Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*), CMS waiver approval, and Exhibit D(f), Section 9 (*Federal Contract Funds*).

B. If Contractor has not already commenced operations, the term of this Contract consists of the following three periods:

1) The Implementation Period;

2) The Operations Period; and

3) The Phaseout Period.

C. The Operations Period will commence at the conclusion of the Implementation Period, subject to DHCS acceptance of Contractor's readiness to begin the Operations Period. The term of the Operations Period is subject to the termination requirements of Exhibit E, Subsections 1.1.16 (*Termination*) and 1.1.19, (*Sanctions*), and subject to the limitation provisions of Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*).

D. The Phaseout Period will commence on the date the Operations Period or Contract extension ends. The Phaseout Period will extend until all

Back to Agenda Back to Item

activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

E. If Contractor has commenced operations as of the effective date of this Contract, the term of the Contract consists of the Operations Period and the Phaseout Period. The term of the Operations Period is subject to the termination requirements of Exhibit E, Subsections 1.1.16 (*Termination*) and 1.1.19 (*Sanctions*) below and subject to the limitation requirements of Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*).

1.1.14 Service Area

The Service Area covered under this Contract includes:

Orange County

Unless otherwise specified in this Contract, all Contract provisions apply separately to each Service Area. This Contract may expire for some Service Areas and remain in effect for others with each Service Area having its own Operations and Phaseout Periods.

1.1.15 Contract Extension

DHCS has the exclusive option to extend the term of the Contract for any Service Area during the last 12 months of the Contract, as determined by the original expiration date or by a new expiration date if an extension option has been exercised. Contractor will be given at least nine months prior written notice of DHCS' decision on whether it will exercise this option to extend the Contract for each Service Area.

Contractor will provide written notification to DHCS of its intent to accept or reject the Contract extension within five Working Days of the receipt of the notice from DHCS.

1.1.16 Termination

A. DHCS-Initiated Terminations

1) Mandatory Termination

a) DHCS must terminate this Contract in the event of any of the following:

Back to Agenda Back to Item

i. The Secretary of the U.S. Department of Health & Human Services (U.S. DHHS) determines that Contractor does not meet the requirements for participation in the Medicaid program (42 United States Code (USC) section 1396);

ii. DMHC finds that Contractor no longer qualifies for licensure under the KKA (Health and Safety Code (H&S) section 1340 *et seq.*), if licensure is required; or

iii. The Director determines the health and welfare of Members is jeopardized by continuation of the Contract.

b) Termination pursuant to Subsection 1.16.A.1 (*Mandatory Termination*) will be effective immediately. Termination under this Section 1.16.A does not relieve Contractor of its obligations under Exhibit E, Section 1.17 (*Phaseout Requirements*).

2) Termination for Cause

a) DHCS may terminate this Contract and be relieved of any payments should Contractor fail to perform the requirements of this Contract. In the event of such termination, DHCS may proceed with providing the services required under this Contract in any manner deemed proper by DHCS. All costs to the State will be deducted from any sum due Contractor under this Contract and the balance, if any, will be paid to Contractor upon demand.

b) DHCS will provide Contractor with at least 60 calendar days' notice prior to the effective date of termination, unless Potential Member harm requires a shorter notice period. Contractor agrees that this notice provision is reasonable. Termination under this Subsection does not relieve Contractor of its obligations under Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

c) DHCS will terminate this Contract under this Subsection, pursuant to the provisions of W&I section 14197.7 and 22 CCR section 53873.

Back to Agenda Back to Item

d) Contractor may dispute termination decisions under this Exhibit E, Subsection 1.1.16 (*Termination*), through the dispute resolution process pursuant to Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*).

3) Permissive Termination

Following a merger or acquisition involving Contractor in which Contractor did not obtain DHCS' express written consent pursuant to Exhibit E, Subsection 1.1.4 (*Assignments, Mergers, Acquisitions*), whether Contractor is the merging party or the acquiring party, DHCS, in its sole discretion, retains the right to terminate this Contract.

a) DHCS will provide written notice of termination to Contractor at least 60 calendar days prior to the effective date of termination.

b) Contractor must fully perform all Contract obligations prior to the effective date of termination. Contractor will not be entitled to additional reimbursement for the services provided following notice of termination until the termination effective date.

c) Termination under this Subsection does not relieve Contractor of its Phaseout Requirement obligations as stated in Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

4) Termination Without Cause

a) DHCS may terminate this Contract and award a new contract for one or more of the Service Areas to another Medi-Cal managed care plan during one of the amendment periods as described in Exhibit E, Subsection 1.1.15 (*Contract Extension*).

b) Notwithstanding any other provision in this Contract, DHCS may terminate this Contract in whole or in part at any time at DHCS' sole discretion.

c) DHCS will notify Contractor of termination under this Exhibit E, Subsection 1.1.16 (*Termination*) at least six months prior to the effective date of termination to allow for all Phaseout Requirements to be completed.

Back to Agenda Back to Item

B. Contractor-Initiated Terminations

Contractor may only terminate this Contract under one or more of the following circumstances:

1) For Rating Periods subsequent to Calendar Year 2024, if Contractor does not accept the Capitation Payment rates determined by DHCS, or if DHCS decides to negotiate the Capitation Payment rates and the parties do not agree on the rates; or

2) When a change in contractual obligations is created by a State or federal change in the Medi-Cal program or a lawsuit that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the term of the Contract, the following will apply:

   a) Contractor will submit a detailed written financial analysis to DHCS supporting its conclusions that it cannot remain financially solvent. At DHCS' request, Contractor will submit or otherwise make available to DHCS all of Contractor's financial work papers, financial reports, financial books and other records, bank statements, computer records, and any other information requested by DHCS to evaluate Contractor's financial analysis;

   b) DHCS and Contractor may negotiate an earlier termination date than the termination date set forth in this Subsection 1.16.B, if Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this Subsection;

   c) Contractor must provide at least a six-month written notice of termination under this Exhibit E, Subsection 1.1.16 (*Termination*). The effective date of termination will be December 31 of the year in which Contractor gives notice, unless the date of notice is less than six months before December 31. In that event, termination under this Exhibit E, Subsection 1.1.16 (*Termination*) will be effective no earlier than December 31 of the following year.

Back to Agenda Back to Item

d) Termination under these circumstances does not relieve Contractor of its obligations as stated in Exhibit E, Subsection 1.1.17 (*Phaseout Requirements).*

C. Termination of Obligations

Contractor's obligations to provide Covered Services under this Contract or under any Contract extension terminate on the date the Operations Period ends.

D. Notice to Members of Transfer of Care

Following notice of termination by either DHCS or Contractor, notice to the Member will be directed by DHCS. Contractor will not send any notices to its Members regarding the termination unless it receives prior approval from DHCS.

1.1.17 Phaseout Requirements

A. DHCS will retain Capitation Payment for each Service Area from Contractor's Capitation Payment for the last four months of the Operations Period for each Service Area, or Contractor must provide a performance bond to DHCS of an equal amount, until all Directive Payment Initiatives and Supplemental Payments have been calculated and processed by DHCS and all activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

Upon DHCS' processing of all Directive Payment Initiatives and Supplemental Payments and the completion of all Phaseout Period activities for each Service Area, the withhold will be paid to Contractor or the performance bond will be released. If Contractor fails to meet any requirements of the Phaseout Period for each Service Area, DHCS will deduct the costs of the remaining activities from the withhold amount and continue to withhold payment until all activities are completed.

B. The objective of the Phaseout Period is to ensure that, in connection with the expiration or termination of this Contract, Contractor ensures an orderly transfer of necessary data and history records to DHCS or to a successor Medi-Cal managed care plan. Contractor will not provide services to Members during the Phaseout Period.

Within no later than 90 calendar days prior to termination or expiration of this Contract and through the Phaseout Period for each Service Area, Contractor must assist DHCS in the transition of Members and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, Contractor will make available to DHCS, without additional compensation, copies of each Member's Medical Records and files, and any other pertinent information, including information maintained by any Subcontractor, Downstream Subcontractor, or Network Provider, necessary to provide effected Members with case management and continuity of care. In no circumstances will a Medi-Cal Member be billed for this activity.

C. Phaseout for this Contract includes processing, payment, and monetary and data reconciliations necessary regarding Provider claims for Covered Services.

1) Phaseout for this Contract includes the completion of all financial and reporting obligations of Contractor. Contractor will remain liable for the processing and payment of invoices and other claims for payment for Covered Services and other services provided to Members prior to the expiration or termination of this Contract. Contractor must timely submit to DHCS all reports required in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) for the period from the last submitted report through the expiration or termination date, and Contractor will be obligated to cooperate with DHCS with regard to the reconciliation of Contractor's Encounter Data Reporting and Network Provider Data Reporting for up to two years following the expiration or termination of this Contract.

2) All data and information provided by Contractor will be accompanied by a letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials provided.

D. The Phaseout Period will commence on the date the Operations Period of the Contract or Contract extension ends. Phaseout related activities are non-payable obligations and services.

1.1.18 Indemnification

A. As a condition of entering into this Contract, Contractor agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents, and employees from any and all claims and losses accruing or

Back to Agenda Back to Item

resulting from any and all Network Providers, Subcontractors, Downstream Subcontractors, suppliers, laborers, and any other person, firm, or corporation furnishing or supplying work services, materials, or supplies in connection with the performance of this Contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by Contractor in the performance of this Contract.

B. Contractor further agrees to indemnify, defend, and hold harmless the State, DHCS and its officers, agents, and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, and any Administrative Costs incurred by DHCS or a Member from any and all litigation, arbitration or mediation resulting directly, indirectly, or arising out of Contractor's denial, delay, or modification of requested Covered Services.

C. Contractor further agrees to indemnify, defend, and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, including DHCS' defense costs, judgments, damages, any Administrative Costs incurred from claims that Contractor violated the Telephone Consumer Protection Act of 1991, 47 USC section 227 *et seq*., and/or related Federal Communications Commission regulations in the performance of this Contract.

D. Contractor further agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any Administrative Costs incurred to the extent DHCS is required to provide notice to affected Members and Potential Members, and any other costs associated with any actual or alleged breach, by Contractor and any vendor, Subcontractor, Downstream Subcontractor, or Network Provider Contractor contracts with in the performance of this Contract, of the following statutes and regulations: the of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), 42 USC section 17921 *et seq.*, and their implementing privacy and security regulations at 45 CFR parts 160 and 164 and the Information Practices Act, and Civil Code (CC) section 1798 *et seq.* by Contractor.

E. DHCS is authorized to withhold any and all attorneys' fees and costs, judgments, damages, any Administrative Costs incurred pursuant to this indemnification agreement, from Contractor's next Capitation Payment or

Back to Agenda Back to Item

any other method to recoup DHCS' costs from Contractor.

1.1.19 Sanctions

A. Contractor is subject to sanctions and civil penalties for the specific conduct set forth in 42 CFR sections 438.700, 438.702, 438.704, 438.706, and 438.708. DHCS is also authorized to impose additional sanctions on Contractor pursuant to 42 CFR section 438.702(b) as set forth in W&I section 14197.7, APL 23-012, and any other applicable law.

B. Monetary sanctions imposed pursuant to W&I section 14197.7 may be separately and independently assessed and may also be assessed for each day Contractor fails to correct an identified deficiency. For deficiencies that impact Members and Potential Members, each impacted Member or Potential Member constitutes a separate violation for the purposes of imposing a monetary sanction.

C. Good cause for imposing monetary sanctions includes but is not limited to a breach of this Contract, a violation of a legal obligation (including, but not limited to, obligations imposed by statute, regulation, APL, PL, or other DHCS Guidance), a finding of deficiency that results in an improper denial or delay in the delivery of health care services, potential endangerment of a Member's care, disruption in Contractor's Network, failure to approve continuity of care for a Member, failure to timely and correctly reimburse claims, or a delay in required reporting to DHCS. Further grounds for imposing sanctions include, but are not limited to, those set forth in 42 CFR section 438.700 et seq., W&I section 14197.7, and APL 23-012.

D. DHCS may identify findings of noncompliance or good cause through any means, including, but not limited to, findings in audits; investigations; contract compliance reviews; Quality Improvement System monitoring; routine monitoring; facility site surveys; Encounter Data submissions; Grievances and Appeals; Network adequacy reviews; assessments of timely access requirements; reviews of utilization data; health plan rating systems; State Hearing decisions; IMR decisions; complaints from Members, Providers, Network Providers, Subcontractors, Downstream Subcontractors, other stakeholders, or whistleblowers; and Contractor's self-disclosures.

E. Sanctions in the form of denial of payments provided for under this Contract for new Members will be taken, when and for as long as, payment for those Members is denied by CMS under 42 CFR section 438.730.

F. DHCS may also impose nonmonetary sanctions as set forth in 42 CFR section 438.700 et seq., W&I section 14197.7, APL 23-012, and any other applicable law.

G. DHCS is not required to impose a Corrective Action plan on Contractor before imposing any of the sanctions set forth in this Section or in State and federal law.

H. DHCS may impose sanctions in addition to any monetary damages recovered pursuant to Exhibit E, Subsection 1.1.20 (*Liquidated Damages*).

1.1.20 Liquidated Damages

A. If Contractor breaches this Contract, DHCS will be entitled to all legal and equitable remedies available under the law, including monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages.

B. Contractor agrees that any breach of this Contract, including but not limited to a breach due to Contractor's delay in implementing new program requirements or plan readiness requirements or Contractor's failure to meet its Quality or Network Adequacy obligations, may result in damage to the State or DHCS that is difficult to quantify. In the event of such a breach, Contractor agrees that the Director is authorized to impose liquidated damages on Contractor in the amount of $25,000 for each separate and distinct breach in addition to liquidated damages in the amount of $25,000 for each day Contractor fails to remedy the breach, which the Parties agree bears a reasonable relationship to the range of actual damages the Parties anticipate would flow from such a breach.

C. Contractor acknowledges that DHCS' authority to impose monetary sanctions and other intermediate sanctions pursuant to 42 CFR section 438.700 *et seq*. and W&I section 14197.7, as set forth in Exhibit E, Subsection 1.1.19 (*Sanctions*), is separate and distinct, and that DHCS may recover damages for Contractor's breach, including liquidated damages, in addition to any sanctions imposed under Exhibit E, Subsection 1.1.19 *(Sanctions).*

1.1.21 Contractor's Dispute Resolution Requirements

Contractor must comply with and exhaust the requirements of this Section when it initiates a contract dispute with DHCS. This Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*) does not apply to challenges to sanctions as described in Exhibit E, Subsection 1.1.19 *(Sanctions)* liquidated

Back to Agenda Back to Item

damages as described in Exhibit E, Subsection 1.1.20 *(Liquidated Damages)*, or any other contract compliance action initiated by DHCS. Contractor's filing of a Notice of Dispute, as defined in Paragraph B of this Section, does not preclude DHCS from withholding or recouping the value of the amount in dispute from Contractor, or from offsetting the amount in dispute from subsequent Capitation Payment(s).

A. Resolution of Dispute by Negotiation

Contractor agrees to make best efforts to resolve all alleged contractual issues by negotiation and mutual agreement at the DHCS Contracting Officer level before appealing to the DHCS Office of Administrative Hearings and Appeals (OAHA). Contractor must exhaust OAHA's appeal process before filing a writ in Sacramento County Superior Court. During the negotiations to resolve Contractor's issues, DHCS and Contractor may agree, in writing, to an extension of time for continuing negotiations to resolve Contractor's dispute before the decision of the DHCS Contracting Officer is issued.

B. Notice of Dispute

Within 30 calendar days from the date that the alleged dispute arises or otherwise becomes known to Contractor, Contractor must serve a written notice of dispute to the DHCS Contract Manager. Contractor's failure to serve its notice of dispute within 30 calendar days from the date the alleged dispute arises or otherwise becomes known to Contractor constitutes a waiver of all issues raised in Contractor's notice of dispute.

Contractor's notice of dispute must include, based on the most accurate information and substantiating documentation available to Contractor, the following:

1) That the dispute is subject to the procedures in this Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*);

2) The date, nature, and circumstances of the alleged conduct that is subject of the dispute;

3) The names, phone numbers, functions, and conduct of every Subcontractor, Downstream Subcontractor, Network Provider, DHCS/State official or employee involved in or knowledgeable of the alleged issue(s) that is the subject of the dispute;

Back to Agenda Back to Item

4) The identification of any substantiating documents and the substance of any oral communications that are relevant to the alleged conduct;
5) Copies of all substantiating documentation and any other evidence attached to its notice of dispute;

6) The factual and legal bases supporting Contractor's notice of dispute;

7) The cost impact to Contractor directly attributable to the alleged conduct, if any; and

8) Contractor's desired remedy.

After Contractor submits its notice of dispute with all accurate available substantiating documentation, Contractor must comply with 22 CCR section 53851(d) and diligently continue performance of its obligations under this Contract, including compliance with contract requirements that are the subject of, or related to, Contractor's notice of dispute.

If Contractor requests and DHCS agrees, Contractor's notice of dispute may be decided by an alternate dispute officer (ADO). DHCS will designate an ADO who was not directly involved in the alleged conduct that prompted Contractor's notice of dispute.

Any appeal of the DHCS Contracting Officer's decision to OAHA or a writ seeking review of OAHA's decision in Sacramento County Superior Court is limited to the issues and arguments set forth and properly documented in Contractor's notice of dispute, that were not waived or resolved.

C. Timeframes

The DHCS Contracting Officer or ADO will have 90 calendar days to review Contractor's initial notice of dispute and available substantiating documentation and issue a decision unless there is a written agreement between DHCS and Contractor to extend that time. If the DHCS Contracting Officer or ADO determines that additional substantiating documentation is required, they will provide Contractor with a written request identifying the issue(s) requiring additional supporting documentation. Contractor must provide that additional substantiating documentation no later than 30 calendar days from receipt of the request.

Unless Contractor and the DHCS Contracting Officer or ADO agree to an extension of time, in writing, Contractor's failure to provide additional

Back to Agenda Back to Item

substantiating documentation, or otherwise notify the DHCS Contracting Officer or ADO that no additional documents exist, within 30 calendar days from the request, constitutes Contractor's waiver of all issues raised in Contractor's notice of dispute.

Issues raised by Contractor in the notice of dispute will be decided by the DHCS Contracting Officer or the ADO within 90 calendar days from receipt of Contractor's substantiating documentation or within 60 calendar days from receipt of all additionally requested substantiating documentation from Contractor, whichever is later.

D. The DHCS Contracting Officer's or ADO's Decision

1) If the DHCS Contracting Officer or the ADO finds in favor of Contractor, they may:

a) Correct the conduct which prompted Contractor's notice of dispute; or

b) Require performance of the disputed conduct and, if there is a cost impact sufficient to constitute a material change in obligations pursuant to the payment provisions under Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*), direct DHCS to comply with that Exhibit. In the event of such a finding DHCS will not owe interest on any underpayment found due and owing pursuant to the notice of dispute.

2) If DHCS' Contracting Officer or the ADO denies Contractor's notice of dispute, they are authorized to direct the manner of Contractor's future contractual performance.

E. Appeal of the DHCS Contracting Officer's or ADO's Decision

1) Contractor will have 30 calendar days following the receipt of DHCS Contracting Officer's or ADO's decision to appeal the decision to the Director, through OAHA. All of Contractor's appeals will be governed by H&S section 100171, except Government Code (GC) section 11511 relating to depositions will not apply. The venue of OAHA appeals will be in Sacramento.

2) All of Contractor's appeals must be in writing and must be filed with OAHA and a copy sent to the Chief Counsel of DHCS and DHCS Contract Manager. Contractor's appeal will be deemed filed on the date it is received by OAHA. Contractor's appeal must specifically

Back to Agenda Back to Item

set forth the unresolved issues that remain in dispute and issues that have not been waived because of Contractor's failure to provide all substantiating documentation to DHCS, as specified in Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*). Additionally, Contractor's appeal is solely limited to the issues raised in its notice of dispute that have not been resolved or waived.

3) Contractor has the burden of proof of demonstrating that its position is correct and must show by a preponderance of evidence that:

   a) DHCS acted improperly such that it breached this Contract; and

   b) Contractor sustained a cost impact directly related to DHCS' breach.

4) OAHA's jurisdiction is limited to issues and arguments raised in the notice of dispute that were not waived either by the untimely filing of the notice of dispute or statement of disputed issues, or by Contractor's failure to provide all requested substantiating documentation requested by DHCS Contracting Officer or ADO or otherwise resolved by Contractor and DHCS.

5) Contractor's failure to timely appeal the decision to OAHA constitutes a waiver by Contractor of all issues raised in Contractor's notice of dispute. This waiver of claims also precludes the filing of a writ in Sacramento Superior Court, or any other court.

F. No Obligation to Pay Interest

If Contractor prevails on its notice of dispute pursuant to a DHCS Contracting Officer's or ADO's decision, an OAHA decision, or an order or decision issued by any State or federal court, including any State or federal court of appeal, or any order, decision, opinion, or award issued in any other forum, DHCS will not be required to pay interest on any amounts found to be due or owing to Contractor arising out of the notice of dispute.

G. Contractor's Duty to Perform

Contractor must comply with all requirements of 22 CCR section 53851(d) and all obligations under this Contract, including continuing Contract requirements that are the subject of, or related to, Contractor's notice of

Back to Agenda Back to Item

dispute until there is a final decision from the DHCS Contracting Officer, the ADO or a decision on an appeal in Sacramento County Superior Court.

H. Waiver of Claims

Contractor waives all claims or issues if it fails to timely submit a notice of dispute with all substantiating documents within the timeframes noted in Subsection 1.1.21.C, above. Contractor also waives all claims or issues set forth in its notice of dispute if it fails to timely submit all additional substantiating documentation within 30 calendar days of the DHCS Contracting Officer's or ADO's request, or if it fails to timely appeal the DHCS Contracting Officer's or ADO's decision in the manner and within the time specified in this Subsection 1.1.21. Contractor's waiver includes all damages whether direct or consequential in nature.

1.1.22 Inspection and Audit of Records and Facilities

A. Recordkeeping Requirements

1) Records to be Maintained

Contractor must maintain all records and documents necessary to disclose how Contractor discharges its obligations under this Contract. These records and documents will disclose the quantity of Covered Services provided under this Contract, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the manner in which Contractor administered its daily business, and the cost thereof.

Contractor must maintain all working papers, reports submitted to (DHCS, DMHC, Division of Medi-Cal Fraud & Elder Abuse (DMFEA), United States Department of Health & Human Services (U.S. DHHS), and United States Department of Justice (US DOJ), financial records, books of account, Medical Records, prescription files, laboratory results, Subcontractor Agreements, Downstream Subcontractor Agreements, and Network Provider Agreements, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members.

In addition, and in accordance with 42 CFR section 438.3(u), Contractor must retain the following information for no less than ten years and allow auditing entities to inspect and audit:

a) Member Grievance and Appeal records as required in 42 CFR section 438.416;

b) Base data as defined in 42 CFR section 438.5(c);

c) MLR reports as required in 42 CFR section 438.8(k); and

d) Data, information, and documentation specified in 42 CFR sections 438.604, 438.606, 438.608, and 438.610.

2) Records Retention Period

Notwithstanding any other records retention time period set forth in this Contract, Contractor must maintain all records and documents described in this Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*) for a minimum of ten years from the final date of the Phaseout Period or from the date of completion of any audit, whichever is later, in accordance with 42 CFR sections 438.3(h) and (u) and 438.230(c).

B. Right to Audit and Inspect Records and Facilities

1) Authorized Agencies

Contractor agrees that the following agencies, including but not limited to, DHCS, the Centers for Medicare & Medicaid Services (CMS), U.S. DHHS, U.S. DHHS Office of the Inspector General, the Comptroller General of the United States, US DOJ, DMFEA, DMHC, the External Quality Review Organization (EQRO) contractor, and all other agencies authorized under State and federal law (authorized agencies), and their duly authorized representatives or designees, will have the right to audit and inspect the records and documents in the form or manner in which the authorized agencies request, and facilities of Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers.

Back to Agenda Back to Item

2) Right to Audit and Inspect at Any Time

DHCS, and its designees, and other authorized agencies and their designees, may, at any time, inspect and audit any and all records, documents, contracts, computers, or other electronic systems maintained by Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers in the form or manner in which the authorized agencies request, and may, at any time, inspect the premises, facilities, and equipment pertaining directly or indirectly to the delivery of Medi-Cal services pursuant to 42 CFR sections 438.3(h) and (u) and 438.230(c), and other applicable State and federal law.

3) Scope of Inspection

DHCS and other authorized agencies may, at any time, audit, inspect, and monitor, Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers, to assure compliance with any provision of this Contract; evaluate the quality, appropriateness, and timeliness of services performed under this Contract; and for any other reasonable purpose.

Upon request, and through the end of the records retention period specified in Exhibit E, Subsection 1.1.22.A.2 (*Inspection and Audit of Records and Facilities*), Contractor must furnish any record, or copy of it, to DHCS or any other auditing entity listed in this Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*), at Contractor's sole expense.

4) Right to Audit and Inspect Exists for Ten Years

The right to audit and inspect under this this Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*) exists for ten years from the final date of the Contract Phaseout Period or from the date of completion of any audit, whichever is later, in accordance with 42 CFR sections 438.3(h) and (u) and 438.230(c).

5) Additional Facility Inspection Rights

In addition to Exhibit D(f), Section 8 (*Site Inspection*) in order to ensure compliance with this Contract, and for any other reasonable purpose, Contractor agrees to the following:

Back to Agenda Back to Item

a) DHCS, and its authorized representatives and designees, and authorized agencies, and their authorized representatives and designees, will have the right to access the premises and facilities of Contractor, and the premises and facilities of its Subcontractors, Downstream Subcontractors, and Network Providers, with or without notice, including, but not limited to, the management information systems operations site or such other places where duties and obligations under the Contract are performed.

b) Staff designated by DHCS, and the designated staff of other authorized agencies, must be provided access to security areas of all Contractor, and its Subcontractors, Downstream Subcontractors,' and Network Providers, . Contractor must provide, and must require any and all of its Subcontractors, Downstream Subcontractors, and Network Providers to provide, reasonable cooperation and assistance to auditing representatives in the performance of their duties.

c) DHCS may conduct unannounced inspections and audits of the premises and facilities of Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers, selected at DHCS' sole discretion, to verify compliance of these sites with DHCS requirements.

1.1.23 Confidentiality of Information

In addition to Exhibit D(f), Section 14 (*Confidentiality of Information*), Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

A. Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with 42 CFR section 431.300 *et seq.*, W&I section 14100.2, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members will be protected by Contractor.

Contractor may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Contractor is not required to report to DHCS requests for Medical Records made in accordance with applicable law, unless the law requires such reporting.

Back to Agenda Back to Item

B. With respect to any identifiable information obtained by Contractor, or its Subcontractors, Downstream Subcontractors, or Network Providers, concerning a Member under this Contract, Contractor will ensure the following:

1) Any such information will not be used for any purpose other than carrying out the express terms of this Contract;

2) All requests for disclosure of such information will be promptly transmitted to DHCS, except requests for Medical Records in accordance with applicable law;

3) Any such information will not be disclosed, except as otherwise specifically permitted by this Contract, to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under 42 CFR section 431.300 *et seq.*, W&I section 14100.2, and regulations adopted thereunder; and

4) At the termination of this Contract, the return all such information to DHCS or maintain such information as directed by DHCS.

C. Contractor will have provisions in its Subcontractor Agreements and Network Provider Agreements requiring Subcontractors, Downstream Subcontractors, and Network Providers to comply with this Exhibit E, Subsection 1.1.23 (*Confidentiality of Information*).

1.1.24 Pilot Projects

DHCS may establish pilot projects to test alternative managed care models tailored to suit the needs of populations with special health care needs. The operation of these pilot projects may result in the disenrollment of Members that participate. Implementation of a pilot project may affect Contractor's obligations under this Contract. Any changes in the obligations of Contractor that are necessary for the operation of a pilot project in Contractor's Service Area will be implemented through a contract amendment.

1.1.25 Cost Avoidance and Post-Payment Recovery of Other Health Coverage

A. Contractor must Cost Avoid or make a Post-Payment Recovery **(**PPR) for the reasonable value of services paid by Contractor and rendered to a Member whenever a Member's Other Health Coverage (OHC) covers the same services, fully or partially. However, in no event may Contractor Cost Avoid or seek PPR for the reasonable value of services from a Third-Party Tort Liability (TPTL) action or make a claim against the estates of deceased Members.

B. Contractor must, at a minimum, utilize the Medi-Cal eligibility record for Cost Avoidance and PPR purposes.

C. Contractor retains all monies for PPR when Contractor initiates and completes recovery within 12 months from the date of payment of a service. Any monies for PPR obtained after the 12 months following the date of payment of a service are considered Medi-Cal recoveries and must be remitted to DHCS.

D. If Contractor initiates an active repayment plan with Network Providers or third-party insurance carriers that is agreed upon prior to, and extends beyond 12 months from, the date of payment of a service, Contractor will be allowed to retain the recovered monies.

E. Contractor must coordinate benefits with other coverage programs and entitlements, recognizing the OHC as primary and the Medi-Cal program as the payer of last resort, except for services in which Medi-Cal is required to be the primary payer.

F. If Contractor does not perform PPR for a Member with OHC, Contractor must demonstrate to DHCS, upon request, that the cost of PPR exceeds the total Contract Revenues Contractor projects it would receive from such activity.

G. Cost Avoidance

1) Contractor must not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates third-party coverage, designated by an OHC code or Medicare coverage, without proof that the Provider has first exhausted all sources of other payments. Acceptable forms of proof that all sources of payment have been exhausted or do not apply include a denial letter from the OHC for the service, an explanation of benefits indicating that the service is not covered by the OHC, or documentation demonstrating that

Provider has billed the OHC and received no response for at least 90 calendar days.

2) Contractor must ensure that Providers do not refuse to provide Covered Services to Members, when OHC is indicated on a Member's Medi-Cal eligibility record.

3) Contractor must allow Providers to direct bill services that meet DHCS' requirements for direct billing without attempting to Cost Avoid those services. Cost Avoidance is not required prior to payment for services provided to Members with OHC codes A or N. More information on services that qualify for direct billing can be found in the Medi-Cal Provider Manual, Part 2 – General Medicine, section "Other Health Coverage (OHC): CPT-4 and HCPCS Codes (oth hlth cpt)".

4) Prior to delivering services, Contractor must ensure that Providers review the Member's Medi-Cal eligibility record for third-party coverage, designated by OHC or Medicare coverage code. If the Member's Medi-Cal eligibility record indicates OHC and the requested service is covered by OHC, Contractor must ensure that Providers notify the Member to seek the service from OHC.

5) When Contractor denies a claim due to OHC, Contractor must include OHC information in its notice of claim denial to Provider. OHC information includes, but is not limited to, the name of the OHC or Medicare carrier, and contact or billing information of the OHC.

H. Reporting Requirements for Cost Avoidance

Contractor must report new OHC information not found on the Medi-Cal eligibility record or that is different from what is reflected on the Medi-Cal eligibility record to DHCS within ten calendar days of discovery. Contractor must report discrepancies in the Medi-Cal record by either completing and submitting an OHC removal or addition form found online at https://www.dhcs.ca.gov or reporting OHC information to DHCS in batch updates. Batch updates regarding OHC information are processed by DHCS on a weekly basis. Contractor may contact its DHCS Contract Manager for more information regarding this process.

Back to Agenda Back to Item

I. Post-Payment Recovery

1) Contractor must pay Provider's claim and then seek to recover the cost of the claim by billing the liable third parties in either of the following circumstances:

a) The Member had OHC code A on their Medi-Cal eligibility record at the time of service; or

b) For services defined by DHCS as preventive pediatric services.

2) When Contractor discovers that a service was provided to a Member with OHC designated in the Medi-Cal eligibility record, and Contractor did not properly Cost Avoid the service, then Contractor must bill the OHC for the cost of actual services rendered. If OHC is discovered retroactively, Contractor must also bill the OHC for the cost of actual services rendered.

3) Contractor must bill the liable OHC for the cost of services provided to Members. Billing and recoupment must be completed within 12 months from the date of payment of a service.

4) Monies recovered by DHCS or DHCS' contracted recovery agent starting on the first day of the 13th month after the date of payment of a service will be retained by DHCS.

J. Reporting Requirements

Contractor must submit a monthly PPR Report to DHCS via Secure File Transfer Protocol (SFTP) by the 15th day of each month in a format specified by DHCS in APLs. This report must contain claims and recovery information and any other information specified by DHCS in APLs.

K. Contractor must have written policies and procedures implementing all of the requirements of this Subsection 1.1.25 (*Cost Avoidance and Post-Payment Recovery of Other Health Coverage*).

1.1.26 Third-Party Tort and Workers' Compensation Liability

Contractor must not make a claim for recovery of the value of Covered Services rendered to a Member in cases or instances involving casualty insurance, tort, Workers' Compensation, or class action claims. Contractor's failure to comply with this provision is non-delegable. In the event that Contractor's failure to

comply with this provision negatively impacts DHCS' ability to recover its full statutory lien, DHCS reserves the right to deduct any losses from Contractor's Capitation Payments. To assist DHCS in exercising DHCS' exclusive responsibility for recovering casualty insurance, tort, Workers' Compensation, or class action claims, Contractor must meet the following requirements:

A. Within 30 calendar days of DHCS' request, submit all requested service and utilization information and, when requested, copies of paid invoices/claims for its Members, including information from Network Providers, out-of-Network Providers, Subcontractors, and Downstream Subcontractors. Service and utilization information and copies of paid invoices/claims must set out any services provided by Contractor, including, but not limited to, physical, mental, and dental health services. Records must include services provided on a Fee-For-Service, capitated basis, and any other payment arrangements, regardless of whether a payment was made or denied. The reasonable value of the services must be calculated as the usual, customary, and reasonable charge made to the general public for similar services, or the amount paid to Network Providers or out-of-Network Providers for similar services. No additional payment will be made to Contractor for compliance with this provision.

B. Submit the requested service and utilization information and paid invoices/claims in a form and manner specified by DHCS through DHCS designated SFTP, in compliance with the electronic format and process, as set forth in APLs . Contractor must include the attestation in a form and manner specified by DHCS signed by the custodian of records or a designee with knowledge of the Member Information provided to DHCS, as set forth in APLs.

C. Notify DHCS using the appropriate online notification form at the Third Party Liability and Recovery Division Online Forms page, https://dhcs.ca.gov/PIForms, within ten calendar days of receiving a request from attorneys, insurers, or Members for a lien, pursuant to DHCS' recovery rights. These requirements do not relieve Contractor of other legal duties to Contractor's Members or other entities, including, without limitation, the duty to respond to Members' requests for their own Protected Health Information pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

D. Use the TPLManagedCare@dhcs.ca.gov inbox for all communications regarding Contractor's service and utilization information and copies of paid invoices/claims file submissions, to submit questions or comments related to the preparation and submission of these reports, and for issues related to accessing the SFTP folders.

Back to Agenda Back to Item

E. Have written policies and procedures implementing all of the requirements of this Exhibit E, Subsection 1.1.26 (*Third-Party Tort and Workers' Compensation Liability*).

1.1.27 Litigation Support

A. Records

Upon request by DHCS, Contractor must timely gather, preserve, and provide, in the form and manner specified by DHCS, any information, subject to any lawful privileges, in the possession of Contractor or its Subcontractors, Downstream Subcontractors, or Network Providers, relating to threatened or pending litigation by or against DHCS. If Contractor asserts that any requested documents are covered by a lawful privilege, Contractor must:

1) Sufficiently identify the claimed privileged documents to reasonably identify the documents; and

2) State the privilege being claimed that supports withholding production of the document.

Contractor agrees to promptly provide DHCS with a copy of any documents provided to any party in any litigation by or against DHCS. Contractor acknowledges that time is of the essence in responding to such a request. Contractor will use its best efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records received by Contractor or its Subcontractors, Downstream Subcontractors, or Network Providers related to this Contract or the Subcontractor Agreements, Downstream Subcontractor Agreements, and Network Provider Agreements entered into under this Contract.

B. Document Authentication and Testimony

Contractor will make its personnel and employees available to DHCS to authenticate documents, provide testimony as a witness, act as a "person most knowledgeable," and assist in other ways as requested by DHCS, in connection with litigation, Public Record Acts requests, subpoenas, inquiries, and/or audits by federal and State agencies and departments, and inquiries by third-parties, as requested by DHCS. No additional payments will be paid to Contractor for the activities described in this Exhibit E, Subsection 1.1.27 (*Litigation Support*).

Back to Agenda Back to Item

1.1.28 Equal Opportunity Employer

Contractor must comply with all applicable federal and State employment discrimination laws. Contractor, must:

A. In all solicitations or advertisements for employees placed by or on behalf of Contractor, state that it is an equal opportunity employer;

B. Send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a DHCS-approved notice, advising the labor union or workers' representative of its commitment as an equal opportunity employer and post copies of the notice in conspicuous places available to employees and applicants for employment;

C. Not unlawfully discriminate against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military and veteran status;

D. Ensure that the evaluation and treatment of its employees and applicants for employment are free of such discrimination and comply with the provisions of the Fair Employment and Housing Act (GC §12900 *et seq*.), and the applicable regulations promulgated thereunder (2 CCR § 11000 *et seq.*). The applicable regulations of the Fair Employment and Housing Council implementing GC section 12990, set forth in Subchapter 5 of Division 4.1 of Title 2 of the California Code of Regulations are incorporated into this Contract by reference and made a part hereof as if set forth in full;

E. Give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement; and

F. Include the nondiscrimination and compliance provisions of this clause in all contracts to perform work under the Contract, in accordance with 2 CCR section 11105.

1.1.29 Federal and State Nondiscrimination Requirements

Contractor must:

A. Comply with federal nondiscrimination requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973, as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations promulgated under the above-listed statutes; and

B. Comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, GC sections 7405 and 11135, W&I section 14029.91, and State implementing regulations.

1.1.30 Discrimination Prohibitions

A. Member Discrimination Prohibition

Contractor must not unlawfully discriminate against Members or Potential Members on the basis of any characteristic protected under federal or State nondiscrimination law, including sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, in accordance with the statutes identified in Exhibit E, Subsection 1.1.29 (*Federal and State Nondiscrimination Requirements*) above, rules and regulations promulgated pursuant thereto, or as otherwise provided by law. For the purpose of this Contract, discrimination includes, but is not limited to, unlawfully:

1) Denying any Member Covered Services or availability of a Facility;

2) Providing a Member with any Covered Service that is different, or is provided in a different manner or at a different time from that which is provided to other Members under this Contract except where medically indicated;

3) Subjecting a Member to segregation, separate treatment, or harassment in any manner related to the receipt of any Covered Service;

4) Restricting or harassing a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; treating a Member or Potential Member differently from others in determining whether they satisfy any admission,

Enrollment, quota, eligibility, membership; or adding other requirements or conditions which Members must meet in order to be provided any Covered Service;

5) Assigning times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, to the Members to be served;

6) Utilizing criteria or methods of administration which have the effect of subjecting individuals to discrimination;

7) Failing to make Auxiliary Aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and

8) Failing to ensure meaningful access to programs and activities for Limited English Proficient (LEP) Members and Potential Members.

B. Member Affirmative Action

Contractor must take affirmative action to ensure that Members are provided Covered Services without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, except as needed to provide equal access to LEP Members or Members with disabilities, or where medically indicated. For the purposes of this Section, genetic information includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

C. Discrimination Related To Health Status

Contractor must not discriminate against Members or Potential Members on the basis of their health status or requirements for health care services during Enrollment, re-Enrollment or disenrollment. Contractor must not

terminate the Enrollment of a Member based on an adverse change in the Member's health.

1.1.31 Small Business Participation and Disabled Veteran Business Enterprises Reporting Requirements

A. Contractor must comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at Public Contract (PC) Code section 10230.

B. If for this Contract, Contractor made a commitment to achieve small business participation, then Contractor must annually and within 60 calendar days of receiving final payment under this Contract report to DHCS the actual percentage of small business participation that was achieved (GC § 14841).

C. If for this Contract, Contractor made a commitment to achieve DVBE participation, then Contractor must annually and within 60 calendar days of receiving final payment under this Contract certify in a report to DHCS:

1) The total amount Contractor received under the Contract;

2) The name and address of the DVBE(s) that participated in the performance of the Contract;

3) The amount each DVBE received from Contractor;

4) That all payments under the Contract have been made to the DVBE; and

5) The actual percentage of DVBE participation that was achieved. (Military and Veterans Code § 999.5(d); GC § 14841

1.1.32 Conflict of Interest Avoidance Requirements

Contractor will comply with all requirements relating to Contractor's obligations to avoid conflicts of interest as described in Exhibit H (*Conflict of Interest Avoidance Requirements*).

1.1.33 Guaranty Provision

If Contractor is a subsidiary of another entity, Contractor must submit a guaranty from any entity in Contractor's chain of ownership that is publicly traded. If no such parent entity is publicly traded, the guaranty must be

submitted by a parent entity at a level in the chain of ownership that is acceptable to DHCS. The guaranty must meet all requirements set forth in Exhibit I (*Contractor's Parent Guaranty Requirements*) of this Contract and be in a form satisfactory to DHCS, and provide for the full and prompt performance of all covenants, terms and conditions, and agreements throughout the term of the Contract.

1.1.34 Priority of Provisions

In the event of a conflict between the provisions of Exhibit D(f) (*Special Terms and Conditions*) and any other Exhibits of this Contract, the provisions in the other Exhibits will prevail over the provisions in Exhibit D(f). Additionally, where Exhibit D(f) contains provisions on the same subject matter as a provision in another Exhibit of this Contract, the language in the other Exhibit preempt and prevail over the language in Exhibit D(f).

In the event of a conflict between any Article summary (Articles 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0) and a more specific term in this Contract, the more specific term will prevail over the Article summary.

1.1.35 Additional Incorporated Provisions – Proposals

Any and all final Proposals, including Exhibits and Attachments (collectively referred to as "Proposal"), submitted by Contractor in response to the Request for Proposal 20-10029 (RFP), or any subsequent Requests for Proposal in connection with any managed care contract, are hereby incorporated by reference into this Contract. DHCS is relying on Contractor's representations in Contractor's Proposal in awarding contracts, and, accordingly, DHCS may enforce such representations against Contractor, including, but not limited to, representations that it will perform in a certain manner, provide enhanced services, and/or meet more stringent requirements than those required in the Contract. Contractor is required to obtain written approval from DHCS before implementing any such enhanced services or requirements reflected in Contractor's Proposal. In the event the Proposal(s) does not address Contract requirements, the Contract will govern.

1.1.36 Miscellaneous Provisions

A. Antitrust Claims

By signing this Contract, Contractor hereby certifies that if these services or goods are obtained by means of a competitive bid, Contractor must

comply with the Antitrust Claims requirements of the GC sections 4550 *et seq.*

B. Child Support Compliance Act

Contractor recognizes the importance of Child and family support obligations and must fully comply with all applicable State and federal laws relating to Child and family support enforcement (Chapter 8 (commencing with section 5200) of Part 5 of Division 9 of the Family Code).

C. Priority Hiring Considerations

Contractor must give priority consideration in filling vacancies in positions funded by the Contract to qualified recipients of aid under W&I section 11200 in accordance with PC section 10353.

D. Interoperability

1) Contractor must comply with the CMS Interoperability and Patient Access Final Rule, as set forth in 42 CFR sections 406, 407, 422, 423, 431, 438, 457, 482 and 485, and 45 CFR section 156.

2) Contractor must ensure that its contracted hospitals comply with the electronic notification requirements as set forth in 42 CFR section 482.24(d).

3) Contractor must participate in the California Health and Human Services Data Exchange Framework to exchange health information or provide access to health information to and from various entities in real time as set forth in H&S section 130290.

E. Electronic Visit Verification

All Network Providers who are eligible must comply with Electronic Visit Verification (EVV) requirements.

1) Contractor must collaborate with DHCS, and take action as required by DHCS, to comply with and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers comply with federal requirements for Electronic Visit Verification (EVV) set forth in 42 USC section 1396b(l) and with State requirements for EVV set forth in W&I section 14043.51, Section 12006(a) of the Federal Cures Act, and APL 22-014.

2) Contractor must implement and ensure that its applicable Subcontractors, Downstream Subcontractors, and Network Providers implement a State-approved EVV solution, as required, for personal care services and home health care services provided in a Member's home.

3) Contractor must verify that all Network Providers capture and transmit the following six mandatory data components when providing Personal Care Services and Home Health Care Services in a Member's home:

   a) The type of service performed;

   b) The individual receiving the service;

   c) The date of the service;

   d) The location of service delivery;

   e) The individual providing the service; and

   f) The time the service begins and ends.

4) Contractor must monitor and ensure all Network Providers comply with the EVV requirements when rendering personal care services and home health care services, subject to federal EVV requirements in accordance with APL 22-014 and the established guidelines below:

   a) Monitor providers for compliance with the EVV requirements and Information Notice(s), and alert DHCS to any compliance issues.

   b) Supply Providers with technical assistance and training on EVV compliance.

   c) Require Providers to comply with an approved corrective action plan.

   d) Deny payment if the Provider is not complying with EVV requirements and arrange for Members to receive services from a Provider who does comply.

1.1.37 Data Sharing

A. General Statement

Contractor must transfer all data in compliance with the terms of this Contract, including but not limited to the requirements of Exhibit G (*Business Associate Addendum*). Nothing in this Contract is exhaustive, exclusive, or limiting of DHCS' ability to provide data to Contractor or receive data from Contractor should DHCS determine, in its sole discretion, that the data is necessary and appropriate for Contractor to perform its duties under this Contract.

B. Post-Termination/Expiration Transactions; Survival of Terms

When this Contract terminates or expires, Contractor must continue to exchange data in order to facilitate an orderly phaseout of Contract requirements including, but not limited to, data sharing in connection with continuity of care for Members, Encounter Data reconciliation, Network Provider Data Reporting, and payment reconciliation. These phaseout transactions will require the transfer of data between Contractor and DHCS, including Protected Health Information (PHI) and other potentially sensitive data. To facilitate the safe and secure transfer of data, all requirements of this Contract pertaining to the transfer of data, including but not limited to Exhibit G (*Business Associate Addendum)*, will survive the termination or expiration of this Contract for as long as any PHI or other sensitive data remains in the possession of Contractor. This Subsection is intended to supplement and not replace the requirements of Exhibit G (*Business Associate Addendum*) regarding data sharing.

Exhibit F – Contractor's Release

Contractor's Release

Instructions to Contractor:

With final invoice(s), submit one (1) original and one (1) copy. The original must bear the original signature of a person authorized to bind Contractor. The additional copy may bear photocopied signatures.

Submission of Final Invoice

Pursuant to **contract number** ___ entered into between the Department of Health Care Services (DHCS) and Contractor (identified below), Contractor does acknowledge that final payment has been requested via **invoice number(s)** ___, in the **amount(s) of $** and **dated** ___. If necessary, enter "See Attached" in the appropriate blocks and attach a list of invoice numbers, dollar amounts and invoice dates.

Release of all Obligations

By signing this form, and upon receipt of the amount specified in the invoice number(s) referenced above, Contractor does hereby release and discharge the State, its officers, agents and employees of and from any and all liabilities, obligations, claims, and demands whatsoever arising from the above referenced contract.

Repayments Due to Audit Exceptions / Record Retention

By signing this form, Contractor acknowledges that expenses authorized for reimbursement do not guarantee final allowability of said expenses. Contractor agrees that the amount of any sustained audit exceptions resulting from any subsequent audit made after final payment will be refunded to the State.

All expense and accounting records related to the above referenced contract must be maintained for audit purposes for no less than three years beyond the date of final payment, unless a longer term is stated in said contract.

Recycled Product Use Certification

By signing this form, Contractor certifies under penalty of perjury that a minimum of 0% unless otherwise specified in writing of postconsumer material, as defined in the Public Contract Code Section 12200, in products, materials, goods, or supplies offered or sold to the State regardless of whether it meets the requirements of Public Contract Code Section 12209. Contractor specifies that printer or duplication cartridges offered or sold to the State comply with the requirements of Public Contract Code Section 12156(e).

Reminder to Return State Equipment/Property (If Applicable)

(Applies only if equipment was provided by DHCS or purchased with or reimbursed by contract funds)

Unless DHCS has approved the continued use and possession of State equipment (as defined in the above referenced contract) for use in connection with another DHCS agreement, Contractor agrees to promptly initiate arrangements to account for and return said equipment to DHCS, at DHCS' expense, if said equipment has not passed its useful life expectancy as defined in the above referenced contract.

Patents / Other Issues

By signing this form, Contractor further agrees, in connection with patent matters and with any claims that are not specifically released as set forth above, that it will comply with all of the provisions contained in the above referenced contract, including, but not limited to, those provisions relating to notification to the State and related to the defense or prosecution of litigation.

ONLY SIGN AND DATE THIS DOCUMENT WHEN ATTACHING IT TO THE FINAL INVOICE

Contractor's Legal Name (as on contract):
Signature of Contractor or Official Designee:
Date:

Printed Name/Title of Person Signing:
Distribution: Accounting (Original) Program

Exhibit G – Business Associate Addendum

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations parts 160 and 164 (collectively, and as used in this Agreement)

2. The term “Agreement” as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term “Business Associate” shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by federal and/or State laws.

4.1 As used in this Agreement and unless otherwise stated, the term “PHI” refers to and includes both “PHI” as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act (IPA) at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

4.2 As used in this Agreement, the term “confidential information” refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which State and/or federal privacy and/or security protections apply.

5. Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS’ behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, “use or disclose PHI”) in order to fulfill Business Associate’s obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties.”

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA and/or the IPA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

7. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI,

inclusive of de-identified data derived from such PHI, only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA or other applicable laws if done by DHCS.

7.1 Specific Use and Disclosure Provisions. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person. The person notify the Business Associate of any instances of which the person is aware that the confidentiality of the information has been breached, unless such person is a treatment provider not acting as a business associate of Business Associate.

8. Compliance with Other Applicable Law

To the extent that other State and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable State or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR part 2, W&I section 5328, and Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

Nondisclosure. Business Associate not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.1 Safeguards and Security.

9.1.1 Business Associate use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards be based on applicable Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.1.2 Business Associate, at a minimum, utilize a National Institute of Standards and Technology Special Publication (NIST SP) 800-53 compliant security framework when selecting and implementing its security controls and maintain continuous compliance with NIST SP 800-53 as it may be updated from time to time. The current version of NIST SP 800-53, Revision 5 is available online; updates will be available online at the NIST Computer Security Resource Centerhttps://csrc.nist.gov/publications/sp800.

9.1.3 Business Associate employ FIPS 140-2 validated encryption of PHI at rest and in motion unless Business Associate determines it is not reasonable and appropriate to do so based upon a risk assessment, and equivalent alternative measures are in place and documented as such. FIPS 140-2 validation can be determined online at the NIST Cryptographic Module Validation Program page, with information about the Cryptographic Module Validation Program under FIPS 140-2 available online. In addition, Business Associate maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information.

9.1.4 Business Associate apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.1.5 Business Associate ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement be renewed annually.

9.1.6 Business Associate identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR part 164, subpart C.

9.2 Business Associate's Agent. Business Associate ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. **Mitigation of Harmful Effects**. Business Associate mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. **Access to PHI.** Business Associate make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. **Accounting for Disclosures.** Business Associate make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. **Compliance with DHCS Obligations.** To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR part 164, subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

15. **Access to Practices, Books and Records.** Business Associate make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR part 164, subpart E.

16. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business

Associate determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

17. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

18. **Breaches and Security Incidents.** Business Associate implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS.

18.1.1 Business Associate notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate provide notice by telephone to DHCS.

18.1.2 Business Associate notify DHCS **within 24 hours by email** (or by telephone if Business Associate is unable to email DHCS) of the discovery of the following, unless attributable to a treatment provider that is not acting as a business associate of Business Associate:

18.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

18.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

18.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

18.1.2.4 Potential loss of confidential information affecting this Agreement.

18.1.3 Notice be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, “DHCS Contacts”) using the DHCS Contact Information at Section 18.6. below.

Notice be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and include all information known at the time the incident is reported. The Privacy Incident Reporting Form is available online.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate take:

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable federal and State law.

18.2 Investigation. Business Associate immediately investigate such security incident or breach.

18.3 Complete Report. To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR" include any applicable additional information not included in the Initial Form. The Final PIR Form include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and State laws. The report also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate make reasonable efforts to provide DHCS with such information. A "Supplemental PIR" may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 Notification of Individuals. If the cause of a breach is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate notify individuals accordingly and pay all costs of such notifications, as well as all costs associated with the breach. The notifications comply with

applicable federal and State law. DHCS approve the time, manner and content of any such notifications and their review and approval be obtained before the notifications are made.

18.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate is responsible for all required reporting of the breach as required by applicable federal and State law.

18.6 DHCS Contact Information. To direct communications to the above referenced DHCS staff, the Contractor initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

DHCS Program Contract Manager	**DHCS Privacy Office**	**DHCS Information Security Office**
See the Scope of Work exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. Responsibility of DHCS. DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or State law.

20. Audits, Inspection and Enforcement

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business

Associate promptly remedy any violation of this Agreement and certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate promptly notify DHCS unless it is legally prohibited from doing so.

21. Termination

21.1 **Termination for Cause**. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 **Judicial or Administrative Proceedings.** DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 **Disclaimer**. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. **Amendment**.

22.2.1 Any provision of this Agreement which is in conflict with current or future applicable federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 **Assistance in Litigation or Administrative Proceedings**. Business Associate make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 **No Third-Party Beneficiaries**. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 **Interpretation**. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 **No Waiver of Obligations**. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

Exhibit H – Conflict of Interest Avoidance Requirements

1.0 The Department of Health Care Services (DHCS) requires Contractor to avoid conflicts of interest or the appearance of conflicts of interest. DHCS reserves the right to determine, in DHCS' sole discretion, whether any information received from any source indicates the existence of a potential, suspected, and/or actual conflict of interest.

Exhibit H

1.0 Conflict of Interest Avoidance Requirements

1.1.1 Introduction
1.1.2 Identification of Ownership, Contractual, and Financial Interests
1.1.3 Conflicts of Interest
1.1.4 DHCS Approval of Conflict Avoidance Plan
1.1.5 Third-Party Monitor Oversight
1.1.6 DHCS' Right of Termination
1.1.7 Notice of Conflict of Interest to DHCS

1.0 Conflict of Interest Avoidance Requirements

1.1.1 Introduction

Contractor must ensure that it complies with the conflict of interest avoidance requirements set forth in this Exhibit H and must also ensure the compliance of its employees, officers, and directors throughout the entire term of the Contract, and any extensions thereto. Contractor must also ensure that its Subcontractors and Downstream Subcontractors (as those terms are defined in the Contract), and the employees, officers and directors of Subcontractors and Downstream Subcontractors, comply with the requirements set forth in this Exhibit H throughout the entire term of the Contract, and any extension thereto.

1.1.2 Identification of Ownership, Contractual, and Financial Interests

Contractor will disclose the following to DHCS, in a form and manner directed by DHCS through All Plan Letter (APL) or other similar instructions:

A. Any form of ownership interest, affiliation, financial interest, contractual relationship, and/or control Contractor has in any corporation or other entity that operates as a Medi-Cal managed care health plan, Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), Primary Care Case Management (PCCM), pharmaceutical company or any other health care provider, fiscal intermediary, billing agent, or any other controlling agent for Medi-Cal services (“Medi-Cal Program Participant”); and

B. Any form of ownership interest, affiliation, financial interest, contractual relationship, and/or control Contractor has in any corporation, partnership, limited partnership, limited liability company, sole proprietorship, or any other legal entity that is not a Medi-Cal Program Participant.

To the extent any interest identified by Contractor in Section 1.2 results in a potential, suspected, and/or actual conflict of interest, Contractor will be subject to all requirements of this Exhibit H.

1.1.3 Conflicts of Interest

If Contractor has a potential, suspected, and/or actual conflict of interest, Contractor must provide a description of the relationship and a conflict avoidance plan to ensure that such a relationship will not adversely affect DHCS, other Medi-Cal managed care plans, and/or Medi-Cal Members. In the conflict

avoidance plan, Contractor must also establish procedures to avoid, neutralize, and/or mitigate a potential, suspected, and/or actual conflict of interest.

Any of the following instances would be considered a potential, suspected, and/or actual conflict of interest, including but not limited to any of these instances in the past, present, or future:

A. An instance where Contractor or any of its Subcontractors and Downstream Subcontractors, or any employee, officer, or director of Contractor or any of its Subcontractors and Downstream Subcontractors, has an interest, financial or otherwise, whereby the use or disclosure of information obtained while performing services under the Contract would allow for private or personal benefit or for any purpose that is inconsistent with the goals and objectives of the Contract;

B. An instance where Contractor or any of its Subcontractors and Downstream Subcontractors, or any employee, officer, or director of Contractor or any of its Subcontractors and Downstream Subcontractors, improperly uses their positions for purposes that are, or give the appearance of being, for private gain for themselves or others, such as those with whom they have family, business, or other ties that are determined by DHCS to be a conflict of interest;

C. An instance where Contractor or any of its Subcontractors and Downstream Subcontractors, or any employee, officer, or director of Contractor or any of its Subcontractors and Downstream Subcontractors, gains an unfair competitive advantage due to its unequal access to information, such as where non-public information gained on one contract by Contractor may be leveraged in bidding for another government contract;

    1) Where pursuant to the Political Reform Act (Govt. Code (GC) §§ 87100–87500), a DHCS official has an economic Interest in Contractor and the official makes, participates in the making of, or uses his or her official position to influence the making of a decision involving Contractor where it is reasonably foreseeable that the decision could materially affect the official's economic interest;

    2) Where pursuant to GC section 1090 *et seq*., a DHCS official participates in the making of a Contract with Contractor and the official is financially interested in the Contract;

Back to Agenda Back to Item

3) Where in contravention of Welfare and Institutions Code (W&I) section 14479, a DHCS officer or employee is employed in a management or consultant position by Contractor, Subcontractor, or Downstream Subcontractor one year after the DHCS officer or employee terminates their State employment; and

4) For Two-Plan managed care models, an instance where Contractor will be contracted, affiliated, or otherwise entered into a partnership arrangement to serve as a Local Initiative in the same Two-Plan county where Contractor is operating as the commercial plan, or has indicated an intent to do so.

D. Conflict Avoidance Plan Framework

The requirements of a conflict avoidance plan will vary depending on the nature of the conflict, but must include, at a minimum, the following elements:

1) Clear definitions;

2) Statement of organizational commitment to develop and follow the conflict avoidance plan;

3) Description of the type of conflict of interest (*e.g.*, unequal access to information, impaired objectivity, and/or biased ground rules implicated by a contract);

4) Description of the factors that may or do place Contractor in a potential, suspected, and/or actual conflict of interest situation;

5) If applicable, identification of Subcontractors and Downstream Subcontractors with potential, suspected, and/or actual conflict of interest;

6) Detailed plans for avoiding, neutralizing, and/or mitigating conflicts of interest, or, if not feasible, an explanation and justification for accepting conflicts of interest;

7) Administrative, technical, physical, and management controls, as required in the context of the specific conflict of interest;

8) Provision for third-party monitoring and a requirement that the third-party monitor certify Contractor's compliance with the conflict avoidance plan, if required by DHCS;

9) Contractor's certification of compliance with the conflict avoidance plan; and

10) Provisions requiring periodic review and amendment by Contractor of the conflict avoidance plan to address material changes impacting the conflict of interest.

1.1.4 DHCS Approval of Conflict Avoidance Plan

DHCS, in its sole discretion, will determine whether the specific provisions of the conflict avoidance plan satisfactorily address the actual, suspected, or potential conflicts of interest. DHCS, in its sole discretion, may impose additional requirements or require modification to the conflict avoidance plan, which may include, but are not limited to, the following:

A. Termination of contractual obligations that in DHCS' determination create actual or potential conflicts of interest;

B. Removal of Contractor's management or staff who DHCS determines were involved in the relationship creating the conflict of interest; and/or

C. Creation of an "ethical firewall," with measures to ensure that no information passes between individuals/entities within Contractor's organization that were involved in the conflict and those individuals/entities not involved in the conflict.

These requirements will vary, depending on the nature of the potential, suspected, and/or actual conflicts of interest, the manner in which those potential, suspected, and/or actual conflicts of interest impact the Contract, and DHCS' determination of the best method for addressing those conflicts of interest.

1.1.5 Third-Party Monitor Oversight

DHCS may, in its sole discretion, appoint a third-party monitor to assist in overseeing Contractor's compliance with the conflict avoidance plan. The third-party monitor's responsibilities will include monitoring, reporting, consulting, and, where necessary, investigation of compliance concerns. Appropriate provisions regarding the third-party monitor's duties and Contractor's obligations in connection with the third-party monitor will be included in the conflict avoidance plan.

1.1.6 DHCS' Right of Termination

If DHCS is aware or becomes aware of a potential, suspected, and/or actual conflict of interest, Contractor will be given an opportunity to submit additional information to resolve the conflict of interest. If Contractor has a potential, suspected, and/or actual conflict of interest, Contractor will have five Working Days from the date of notification by DHCS of the potential, suspected, and/or actual conflict of interest to provide complete information regarding the conflict of interest. If DHCS determines that an actual conflict of interest exists and the conflict cannot be resolved or mitigated to the satisfaction of DHCS, the conflict of interest will be grounds for termination of the Contract by DHCS for cause.

1.1.7 Notice of Conflict of Interest to DHCS

Contractor, and each of its Subcontractors and Downstream Subcontractors, must notify their DHCS Contract Manager within ten Working Days of when they become aware of any potential, suspected, or actual conflict of interest, or when any change occurs to the information provided to DHCS previously, whether provided previously through the Request for Procurement or previous notice given during the term of the Contract. This notice will be in a form and manner as directed by DHCS through APL or other similar instructions.

Back to Agenda Back to Item

Exhibit I – Contractor's Parent Guaranty Requirements

1.0 Contractor's Parent Guaranty Requirements

If Contractor is a subsidiary of a corporation or other legal entity, the full and prompt performance of all covenants, provisions, and agreements resulting from this Contract for the life of the Contract must be guaranteed by that entity in Contractor's chain of ownership, which is publicly traded (the "Guaranty"). This entity will be known as Contractor's "parent corporation" for purposes of the Contract (the "Guarantor").

1.1 Contractor's Parent Guaranty Requirements

1.1.1 Minimum Requirements
1.1.2 Provisions
1.1.3 Terms

1.0 Contractor's Parent Guaranty Requirements

1.1.1 Minimum Requirements

The Guaranty must, at a minimum, meet the following requirements. It must:

A. Be made to DHCS, in writing, by the Contract effective date;

B. Be signed by an official authorized to bind the Guarantor organization;

C. Accept unconditional responsibility for all performance and financial requirements and obligations of the Contract including, but not limited to, maintenance of Tangible Net Equity (TNE) and payment of liquidated damages;

D. Recite that "for good and valuable consideration, receipt of which is hereby acknowledged," Guarantor is making the Guaranty;

E. State that Guarantor stipulates that if the Contract is ultimately awarded to the subsidiary, that DHCS will so award in reliance upon the Guaranty;

F. State that the undersigned corporate officer warrants that they have personally reviewed all pertinent corporate documents, including but not limited to, articles of incorporation, bylaws, and agreements between the parent and subsidiary; and

G. State that the undersigned corporate officer warrants that nothing in these documents in any way limits the capacity of the parent to enter into this Guaranty

1.1.2 Provisions

The Guaranty must include the following provisions:

A. DHCS need not take any action against Contractor, any other guarantor, or any other person, firm or corporation, or resort to any security held by Contractor at any time before proceeding against Guarantor;

B. Guarantor hereby waives any and all notices and demands which may be required to be given by any other statute or rule of law and agrees that its liability hereunder will be in no way affected, diminished, or released by any extension of time, forbearance, or waiver, which may be granted to Contractor, its successor or assignee;

Back to Agenda Back to Item

C. This Guaranty will extend to and include all future amendments, modifications, and extensions of the Contract and all future supplemental and other agreements with respect to matters covered by the Contract that DHCS and Contractor may enter into, with or without notice to or knowledge of Guarantor, but Guarantor will have the benefit of any such extension, forbearance, waiver, amendment, modification, or supplemental or other agreement. It is the purpose and intent of the parties hereto that the obligations of Guarantor hereunder will be co-extensive with, but not in excess of, the obligations of Contractor, its successor or assignee, under the Contract; and

D. Guarantor agrees that the Guaranty will continue in full force and effect despite any change in the legal or corporate status of the subsidiary, including, but not limited to, its sale, reorganization, dissolution or bankruptcy.

1.1.3 Terms

The Guaranty must be presented in terms, which DHCS in its sole discretion, determines, as a whole, adequately establish Contractor's financial responsibility.

Exhibit J: Delegation Reporting and Compliance Plan

This Exhibit contains instructions and templates for Contractor to make submissions to DHCS per the requirements set forth in Exhibit A, Attachment III, Subsection 3.1.3 *(Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan)*. As with all Exhibits to the Contract, Exhibit J is a part of this Contract and the reporting requirements in this Exhibit J and the use of the prescribed template are binding and enforceable contractual obligations under this Contract. Contractor must complete Exhibit J for each county in which they operate.

Template A: Delegation Function Matrix

Instructions: Complete *Table A1: Delegation Function Matrix – For Subcontractor* for all functions that are delegated through applicable Subcontractor Agreements. Contractor may not delegate contractual duties and obligations where delegation is legally or contractually prohibited. Use additional pages of Table A1 as needed – additional pages will not be counted in the total page count for the Delegation Justification and Plan.

Contractor Name:

Applicable County:

Compliance Officer:

Compliance Contact Information:

1. **Subcontractor Name:** Name of the Subcontractor with whom Contractor has a Subcontractor Agreement
2. **Type of Subcontractor:** Fully Delegated Subcontractor, Partially Delegated Subcontractor, Administrative Subcontractor

3. **Delegated Function(s):** The function(s) Contractor is delegating to Subcontractor. In the case of a Fully Delegated Subcontractor, this may be “all delegable functions.”

4. **Address:** The address for location of the performance of Subcontractor’s functions

5. **Contact Info:** Name and contact information for each of Subcontractor’s key personnel who is responsible for ensuring compliance.

6. **Medi-Cal Managed Care Member:** Percentage of the total Medi-Cal Members assigned to the Subcontractor if applicable.

7. **Proportion of Capitated Rates At Risk:** Proportion of total capitated rates for which the Subcontractor is at risk, if applicable.

Table A1: Delegation Function Matrix—For Subcontractors

Sub-contractor Name (1)	Type of Sub-contractor (2)	Delegated Function(s) (3)	Address (4)	Contact Info (5)	Percentage of Total Members (6)	Proportion of Total Capitated Rate (7)

Instructions: Complete *Table A2 Delegation Function Matrix—Downstream Subcontractors* for all functions that are delegated through applicable Downstream Subcontractor Agreements. Use additional pages of Table A2 as needed. Subcontractor or Downstream Subcontractor may not delegate contractual duties and obligations where delegation is legally or contractually prohibited. Complete one for each Subcontractor that delegates functions downstream and, as applicable, for each Downstream Subcontractor, if they further delegate functions downstream. Use additional pages of Table A2 as needed – additional pages will not be counted in the total page count for the Delegation Justification and Plan.

Subcontractor or Downstream Subcontractors Name:
Applicable County(ies):
Compliance Officer:
Compliance Contact Information:

1. **Downstream Subcontractor Name:** Name of the Downstream Subcontractor with whom the Subcontractor has a Downstream Subcontractor Agreement; or the name of the Downstream Subcontractor with whom the Subcontractor's Downstream Subcontractor further delegates functions downstream
2. **Type of Downstream Subcontractor:** Downstream Fully Delegated Subcontractor, Downstream Partially Delegated Subcontractor, Downstream Administrative Subcontractor
3. **Delegated Function(s):** The function(s) Subcontractor is delegating to Downstream Subcontractor; in the case of a Downstream Fully Delegated Subcontractor, this may be "all delegable functions."
4. **Address:** The address of the location of the performance of the Downstream Subcontractor's functions.
5. **Contact Info:** Name and contact information for each of the Downstream Subcontractor's key personnel who is responsible for ensuring compliance.
6. **Medi-Cal Managed Care Member:** Percentage of the total Medi-Cal Members assigned to the Downstream Subcontractor, if applicable.
7. **Proportion of Capitated Rates At Risk:** Proportion of total capitated rates for which the Downstream Subcontractor, is at risk, if applicable.

Table A2: Delegation Function Matrix—For Downstream Subcontractors

Downstream Subcontractor Name (1)	Type (2)	Delegated Function(s) (3)	Address (4)	Contact Info (5)	Percentage of Total Members (6)	Proportion of Total Capitated Rate (7)

Back to Agenda Back to Item

Template B: Delegation Justification and Plan

Instructions: Complete this template for each Subcontractor or Downstream Subcontractor. Contractor may not delegate for those contractual duties and obligations where delegation is legally or contractually prohibited. Responses must be limited to no more than ten pages.

Subcontractor or Downstream Subcontractor Name:

Applicable County(ies):

Subcontractor or Downstream Key Personnel:

Subcontractor Key Personnel Contact Information:

Type of Subcontractor or Downstream Subcontractor: Fully delegated, Partially delegated, Administrative, Downstream Fully delegated, Downstream Partially delegated, Downstream Administrative:

a) **Justification of Subcontractor Agreement or Downstream Subcontractor Agreement:** Describe the purpose and the justification of the Subcontractor Agreement or Downstream Subcontractor Agreement.

b) **Pre-Existing Relationships:** Describe any pre-existing relationship, including any affiliation, parent entity, or prior existing contract between Contractor and Subcontractor, or Subcontractor and Downstream Subcontractor including the duration of such pre-existing relationship.

c) **Sub-Delegation**: Indicate if Subcontractor or Downstream Subcontractor is permitted to sub-delegate any functions. If so, describe how Contractor will maintain oversight over delegated functions to Subcontractors and Downstream Subcontractors. Provide citations to provisions in the Subcontractor Agreement and Downstream Subcontractor Agreement to support Contractor's assertions.

d) **Impact on Contractor:** Describe the impact and benefit, if any, the Subcontractor Agreement or Downstream Subcontractor Agreement will have on Contractor's operations, administrative capacity, and financial viability.

e) **Contractor's Administrative Capacity to Oversee and Monitor Subcontractor and Downstream Subcontractor:** Describe Contractor's administrative capacity to oversee and monitor Subcontractor and Downstream Subcontractor as applicable

f) **Subcontractor's and Downstream Subcontractor's Administrative Capacity:** Describe Subcontractor's and Downstream Subcontractor's administrative capacity to perform each delegated function, including but not limited to Subcontractor's and Downstream Subcontractor's capacity to perform quality monitoring and community engagement, if applicable.

g) **Subcontractor's and Downstream Subcontractors' Compliance with Applicable Contractual Provisions:** Detail how the Subcontractor Agreement and Downstream Subcontractor Agreement complies with, and ensures compliance, with all provisions of the Contract applicable to the delegated functions, including appropriate citations to the provisions in the Subcontractor Agreement and Downstream Subcontractor Agreement. Please complete Template C (Contract Requirements Grid) in Exhibit J to indicate which provisions are included in the Subcontractor Agreements and Downstream Subcontractor Agreements, as applicable for each Agreement.

h) **Contractor's Oversight Policy and Procedures:** Describe how Contractor will inform Subcontractor and Downstream Subcontractors of Contractor's oversight policies and procedures.

i) **Financial Arrangement:** Contractor must include description of any financial arrangements it has with Subcontractor and Downstream Subcontractor.

j) **Other Information:** Include any other information that would assist DHCS in its review of Contractor's delegated structure.

k) **Previously Approved Documents: (Applicable to annual submissions only)** If Contractor has previously submitted documentation to DHCS in connection with the Subcontractor Agreement or Downstream Subcontractor Agreement, either through the Request for Proposal (RFP) process or during the term of this Contract, Contractor must provide any such documentation.

Template C: Contract Requirements Grid

Instructions: If you delegate any functions, complete this template for those contractual duties. One Template C should be submitted showing all delegated functions to accompany Templates A and B.

Contractors must complete this table to indicate all the contract requirements that are applicable to their Subcontractors or Downstream Subcontractor, depending on the functions that are delegated to the respective entities.

This table also references obligations of Contractor where delegation must be contractually prohibited. While Contractor must not delegate contractual duties and obligations where delegation is contractually prohibited, Contractor or Subcontractor or Downstream Subcontractor may include related contractual requirements in their Agreements. For example, while Contractor may not delegate the functions of a Compliance Program, they may require Subcontractor and Downstream Subcontractors to maintain their own compliance programs. Regardless of Contractor's system of delegation, Contractor remains obligated to ensure performance of all duties and obligations under the Contract.

Fully Delegated Subcontractors must comply with all contractual requirements. Partially Delegated Subcontractors and Downstream Partially Delegated Subcontractors, and Administrative Subcontractors and Downstream Administrative Subcontractors must at minimum comply with requirements outlined in Exhibit A, Attachment III, Subsection 3.1.5.B *(Subcontractor and Downstream Subcontractor Agreement Requirements)*.

Additional requirements may apply depending on the nature of the function or functions delegated. For example, if a Subcontractor delegates claims processing to an Administrative Downstream Subcontractor for this function, the Administrative Downstream Subcontractor must comply with Exhibit A, Attachment III, Subsection 3.3.5 *(Claims Processing)* for all requirements related to timely processing of claims.

Delegating functions or including contractual provisions in Subcontractor Agreements or Downstream Subcontractor Agreements does not absolve Contractor of ensuring compliance of the Subcontractors or Downstream Subcontractors.

Note:

(1) Must not be delegated: These rows reference contractual requirements associated with functions for which delegation is contractually prohibited. While Contractor must not delegate contractual duties and obligations where delegation is legally or contractually prohibited, Contractor may include related contractual requirements in the Subcontractor Agreements. For example, while Contractor may not delegate the functions of a Compliance Program, they may require Subcontractor and Downstream Subcontractors to maintain their own compliance programs.

Contractor Name:

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
1.0 Organization	
1.1 Plan Organization and Administration	
1.1.1 Legal Capacity	☐
1.1.2 Key Personnel Disclosure Form	☐
1.1.3 Conflict of Interest – Current and Former State Employees	☐
1.1.4 Contract Performance	☐
1.1.5 Medical Decisions	☐
1.1.6 Medical Director	☐
1.1.7 Chief Health Equity Officer	*(1) Must not be delegated*
1.1.8 Key Personnel Changes	☐
1.1.9 Administrative Duties/Responsibilities	☐
1.1.10 Member Representation	☐
1.1.11 Diversity, Equity, and Inclusion Training	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
1.2 Financial Information	
1.2.1 Financial Viability and Standards Compliance	☐
1.2.2 Contractor's Financial Reporting Obligations	☐
1.2.3 Independent Financial Audit Reports	☐
1.2.4 Cooperation with DHCS' Financial Audits	☐
1.2.5 Medical Loss Ratio	*(1) Must not be delegated*
1.2.6 Contractor's Obligations	☐
1.2.7 Community Reinvestment Plan and Report	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
1.3 Program Integrity and Compliance Program	
1.3.1 Compliance Program	*(1) Must not be delegated*
1.3.2 Fraud Prevention Program	☐
1.3.3 Provider Screening, Enrolling, and Credentialing/Recredentialing	☐
1.3.4 Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers	☐
1.3.5 Disclosures	☐
1.3.6 Treatment of Overpayment Recoveries	☐
1.3.7 Federal False Claims Act Compliance and Support	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
2.0 Systems and Processes	
2.1 Management Information System	
2.1.1 Management Information System Capability	☐
2.1.2 Encounter Data Reporting	☐
2.1.3 Participation in the State Drug Rebate Program	☐
2.1.4 Network Provider Data Reporting	☐
2.1.5 Program Data Reporting	☐
2.1.6 Template Data Reporting	☐
2.1.7 Management Information System/Data Audits	☐
2.1.8 Management Information System/Data Correspondence	☐
2.1.9. Tracking and Submitting Alternative Format Selections	☐
2.1.10 Interoperability Application Programming Information System Requirements	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
2.2 Quality Improvement and Health Equity Transformation Program	
2.2.1 Quality Improvement and Health Equity Transformation Program Overview	☐
2.2.2 Governing Board	☐
2.2.3 Quality Improvement and Health Equity Committee	☐
2.2.4 Provider Participation	☐
2.2.5 Subcontractor and Downstream Subcontractor Quality Improvement Activities	☐
2.2.6 Quality Improvement and Health Equity Transformation Program Policies and Procedures	☐
2.2.7 Quality Improvement and Health Equity Annual Plan	☐
2.2.8 National Committee for Quality Assurance Accreditation	*(1) Must not be delegated*
2.2.9 External Quality Review Requirements	☐
2.2.10 Quality Care for Children	☐
2.2.11 Skilled Nursing Facilities—Long-Term Care	☐
2.2.12 Disease Surveillance	☐
2.2.13 Credentialing and Recredentialing	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
2.3 Utilization Management Program	
2.3.1 Prior Authorizations and Review Procedures	☐
2.3.2 Timeframes for Medical Authorization	☐
2.3.3 Review of Utilization Data	☐
2.3.4 Delegating Utilization Management Activities	☐

Contractual Requirements		Delegated to Subcontractor
Exhibit A, Attachment III		
3.0	**Provider, Network Providers, Subcontractors, and Downstream Subcontractors**	
3.1	**Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties**	
3.1.1	Overview of Contractor's Duties and Obligations	☐
3.1.2	DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements	☐
3.1.3	Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan	☐
3.1.4	Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance	*(1) Must not be delegated*
3.1.5	Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements	☐
3.1.6	Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers	☐
3.1.7	Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Federally Qualified Health Centers and Rural Health Clinics	☐
3.1.8	Network Provider Agreements with Safety-Net Providers	☐
3.1.9	Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments	☐
3.1.10	Nondiscrimination in Provider Contracts	☐
3.1.11	Public Records	☐
3.1.12	Requirement to Post	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
3.2 Provider Relations	
3.2.1 Exclusivity	☐
3.2.2 Provider Dispute Resolution Mechanism	☐
3.2.3 Out-of-Network Provider Relations	☐
3.2.4 Contractor's Provider Manual	☐
3.2.5 Network Provider Training	☐
3.2.6 Emergency Department Protocols	☐
3.2.7 Prohibited Punitive Action Against the Provider	☐
3.2.8 Submittal of Inpatient Days Information	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
3.3 Provider Compensation Arrangements	
3.3.1 Compensation and Value Based Arrangements	☐
3.3.2 Capitation Arrangements	☐
3.3.3 Provider Financial Incentive Program Payments	☐
3.3.4 Identification of Responsible Payor	☐
3.3.5 Claims Processing	☐
3.3.6 Prohibited Claims	☐
3.3.7 Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider	☐
3.3.8 Non-Contracting Certified Nurse Midwife, Nurse Practitioner, and Licensed Midwife Providers	☐
3.3.9 Non-Contracting Family Planning Providers	☐
3.3.10 Sexually Transmitted Disease	☐
3.3.11 Human Immunodeficiency Virus Testing and Counseling	☐
3.3.12 Immunizations	☐
3.3.13 Community Based Adult Services	☐
3.3.14 Organ and Bone Marrow Transplants	☐
3.3.15 Long-Term Care Services	☐
3.3.16 Emergency Services and Post-Stabilization Care Services	☐
3.3.17 Provider-Preventable Conditions	☐
3.3.18 Prohibition Against Payment to Excluded Providers	☐
3.3.19 Compliance with Directed Payment Initiatives and Related Reimbursement Requirements	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.0 Member	
4.1 Marketing	
4.1.1 Training and Certification of Marketing Representatives	☐
4.1.2 Marketing Plan	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.2 Enrollments and Disenrollments	
4.2.1 Enrollment	☐
4.2.2 Disenrollment	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.3 Population Health Management and Coordination of Care	
4.3.1 Population Health Management Program Requirements	☐
4.3.2 Population Needs Assessment	☐
4.3.3 Data Integration and Exchange	☐
4.3.4 Medi-Cal Connect (DHCS' PHM Service)	☐
4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering	☐
4.3.6 Screening and Assessments	☐
4.3.7 Care Management Programs	☐
4.3.8 Basic Population Health Management	☐
4.3.9 Other Population Health Requirements for Children	☐
4.3.10 Transitional Care Services	☐
4.3.11 Targeted Case Management Services	☐
4.3.12 Mental Health Services	☐
4.3.13 Alcohol and Substance Use Disorder Treatment Services	☐
4.3.14 California Children's Services	☐
4.3.15 Services for Persons with Developmental Disabilities	☐
4.3.16 School-Based Services	☐
4.3.17 Dental	☐
4.3.18 Direct Observed Therapy for Treatment of Tuberculosis	☐
4.3.19 Women, Infants, and Children Supplemental Nutrition Program	☐
4.3.20 Home and Community-Based Services Programs	☐
4.3.21 In-Home Supportive Services	☐
4.3.22 Indian Health Care Providers	☐
4.3.23 Justice Involved Reentry Coordination	☐

Contractual Requirements	Delegated to Subcontractor
4.3.24 Managed Care Liaisons	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.4 Enhanced Care Management	
4.4.1 Contractor's Responsibilities for Administration of Enhanced Care Management	☐
4.4.2 Populations of Focus for Enhanced Care Management	☐
4.4.3 Enhanced Care Management Providers	☐
4.4.4 Enhanced Care Management Provider Capacity	☐
4.4.5 Enhanced Care Management Model of Care	☐
4.4.6 Member Identification for Enhanced Care Management	☐
4.4.7 Authorizing Members for Enhanced Care Management	☐
4.4.8 Assignment to an Enhanced Care Management Provider	☐
4.4.9 Initiating Delivery of Enhanced Care Management	☐
4.4.10 Discontinuation of Enhanced Care Management	☐
4.4.11 Core Service Components of Enhanced Care Management	☐
4.4.12 Data System Requirements and Data Sharing to Support Enhanced Care Management	☐
4.4.13 Oversight of Enhanced Care Management Providers	☐
4.4.14 Payment of Enhanced Care Management Providers	☐
4.4.15 Enhanced Care Management Reporting Requirements	☐
4.4.16 Enhanced Care Management Quality and Performance Incentive Program	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.5 Community Supports	
4.5.1 Contractor's Responsibility for Administration of Community Supports	☐
4.5.2 DHCS Pre-Approved Community Supports	☐
4.5.3 Community Supports Providers	☐
4.5.4 Community Supports Provider Capacity	☐
4.5.5 Community Supports Model of Care	☐
4.5.6 Identifying Members for Community Supports	☐
4.5.7 Authorizing Members for Community Supports and Communication of Authorization Status	☐
4.5.8 Referring Members to Community Supports Providers for Community Supports	☐
4.5.9 Data System Requirements and Data Sharing to Support Community Supports	☐
4.5.10 Contractor's Oversight of Community Supports Providers	☐
4.5.11 Delegation of Community Supports Administration to Network Providers, Subcontractors, or Downstream Subcontractors	☐
4.5.12 Payment of Community Supports Providers	☐
4.5.13 Community Supports Reporting Requirements	☐
4.5.14 Community Supports Quality and Performance Incentive Program	☐

Contractual Requirements		Delegated to Subcontractor
Exhibit A, Attachment III		
4.6	**Member Grievance and Appeal System**	
4.6.1	Grievance and Appeal Program Requirements	☐
4.6.2	Grievance Process	☐
4.6.3	Discrimination Grievances	☐
4.6.4	Notice of Action	☐
4.6.5	Appeal Process	☐
4.6.6	Responsibilities in Expedited Appeals	☐
4.6.7	State Hearings and Independent Medical Reviews	☐
4.6.8	Continuation of Services Until Appeal and State Hearing Rights Are Exhausted	☐
4.6.9	Grievance and Appeal Reporting and Data	☐

Contractual Requirements		Delegated to Subcontractor
Exhibit A, Attachment III		
5.0	**Services – Scope and Delivery**	
5.1	**Member Services**	
5.1.1	Members Rights and Responsibilities	☐
5.1.2	Member Services Staff	☐
5.1.3	Member Information	☐
5.1.4	Primary Care Provider Selection	☐
5.1.5	Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.2 Network and Access to Care	
5.2.1 Access to Network Providers and Covered Services	☐
5.2.2 Network Capacity	☐
5.2.3 Network Composition	☐
5.2.4 Network Ratios	☐
5.2.5 Network Adequacy Standards	☐
5.2.6 Access to Emergency Service Providers and Emergency Services	☐
5.2.7 Out-of-Network Access	☐
5.2.8 Specific Requirements for Access to Programs and Covered Services	☐
5.2.9 Network and Access Changes to Covered Services	☐
5.2.10 Access Rights	☐
5.2.11 Cultural and Linguistic Programs and Committees	☐
5.2.12 Continuity of Care for Seniors and Persons with Disabilities	☐
5.2.13 Network Reports	☐
5.2.14 Site Review	☐
5.2.15 Street Medicine	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.3 Scope of Services	
5.3.1 Covered Services	☐
5.3.2 Medically Necessary Services	☐
5.3.3 Initial Health Appointment	☐
5.3.4 Services for Members Less Than 21 Years of Age	☐
5.3.5 Services for Adults	☐
5.3.6 Pregnant and Postpartum Members	☐
5.3.7 Services for All Members	☐
5.3.8 Investigational Services	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.4 Community Based Adult Services	
5.4.1 Covered Services	☐
5.4.2 Coordination of Care	☐
5.4.3 Required Reports for the Community Based Adult Services Program	☐
5.4.4 Community Participation	☐
5.4.5 Community Based Adult Services Program Integrity	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.5 Mental Health and Substance Use Disorder Benefits	
5.5.1 Mental Health Parity Requirements	☐
5.5.2 Non-specialty Mental Health Services and Substance Use Disorder Services	☐
5.5.3 Non-specialty Mental Health Services Providers	☐
5.5.4 Emergency Mental Health and Substance Use Disorder Services	☐
5.5.5 Mental Health and Substance Use Disorder Services Disputes	☐
5.5.6 No Wrong Door for Mental Health Services	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.6 MOUs with Local Government Agencies, County Programs, and Third Parties	
5.6.1 MOU Purpose	☐
5.6.2 MOU Requirements	☐
5.6.3 MOU Oversight and Compliance	☐

Contractual Requirements		Delegated to Subcontractor
Exhibit A, Attachment III		
6.0	**Emergency Preparedness and Response**	
6.1	General Guidance	☐
6.2	Business Continuity Emergency Plan	☐
6.3	Member Emergency Preparedness Plan	☐
6.4	California's Standardized Emergency Management System	☐
6.5	Reporting Requirements During an Emergency	☐
6.6	DHCS Emergency Directives	☐

Contractual Requirements		Delegated to Subcontractor
Exhibit A, Attachment III		
7.0	**Operations Deliverables and Requirements**	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit E	
1.0 Program Terms and Conditions	
1.1.1 Governing Law	☐
1.1.2 DHCS Guidance	☐
1.1.3 Contract Interpretation	☐
1.1.4 Assignments, Mergers, Acquisitions	☐
1.1.5 Independent Contractor	☐
1.1.6 Amendment and Change Order Process	☐
1.1.7 Delegation of Authority	*(1) Must not be delegated*
1.1.8 Authority of the State	☐
1.1.9 Fulfillment of Obligations	☐
1.1.10 Obtaining DHCS Approval	☐
1.1.11 Certifications	☐
1.1.12 Notices	☐
1.1.13 Term	☐
1.1.14 Service Area	☐
1.1.15 Contract Extension	☐
1.1.16 Termination	☐
1.1.17 Phaseout Requirements	☐
1.1.18 Indemnification	☐
1.1.19 Sanctions	☐
1.1.20 Liquidated Damages	☐
1.1.21 Contractor's Dispute Resolution Requirements	☐
1.1.22 Inspection and Audit of Records and Facilities	☐
1.1.23 Confidentiality of Information	☐

Contractual Requirements	Delegated to Subcontractor
1.1.24 Pilot Projects	☐
1.1.25 Cost Avoidance and Post-Payment Recovery (PPR) of Other Health Coverage (OHC)	☐
1.1.26 Third-Party Tort and Workers' Compensation Liability	☐
1.1.27 Litigation Support	☐
1.1.28 Equal Opportunity Employer	☐
1.1.29 Federal and State Nondiscrimination Requirements	☐
1.1.30 Discrimination Prohibitions	☐
1.1.31 Small Business Participation and Disabled Veteran Business Enterprises (DVBE) Reporting Requirements	☐
1.1.32 Conflict of Interest Avoidance Requirements	*(1) Must not be delegated*
1.1.33 Guaranty Provision	☐
1.1.34 Priority of Provisions	☐
1.1.35 Additional Incorporated Provisions – Proposals	☐
1.1.36 Miscellaneous Provisions	☐
1.1.37 Data Sharing	☐

Exhibit K – Excluded Provisions as to Contractors Not Licensed Pursuant to the Knox-Keene Health Care Service Plan Act of 1975

Unless otherwise specified in this Contract, the following provisions of the Knox-Keene Health Care Service Plan Act of 1975, (KKA), and its implementing regulations (~~22~~**28** California Code of Regulations (CCR) section 1000, *et seq*.) are excluded from this Contract if Contractor is not licensed to operate as a health care service plans pursuant to the KKA. This list is not exhaustive or exclusive since other provisions of the KKA may also be excluded from the Contract pursuant to Exhibit E, Section 1.1.D (*Applicability of the Knox-Keene Act*) or other provisions of the Contract:

1. Health and Safety Code (H&S) sections 1341 – 1341.14.
2. H&S sections 1342.4 – 1342.73.
3. H&S sections 1346 – 1347.5.
4. H&S sections 1348.9 – 1348.96.
5. H&S, Article 3 of Chapter 2.2 of Division 2.
6. H&S, Article 3.1 of Chapter 2.2 of Division 2.
7. H&S, Article 3.15 of Chapter 2.2 of Division 2.
8. H&S, Article 3.16 of Chapter 2.2 of Division 2.
9. H&S, Article 3.17 of Chapter 2.2 of Division 2.
10. H&S, Article 3.5 of Chapter 2.2 of Division 2.
11. H&S sections 1359 – 1361.1.
12. H&S section 1363.01.
13. H&S section 1363.03.
14. H&S section 1363.05.
15. H&S, Article 4.5 of Chapter 2.2 of Division 2.
16. H&S sections 1367.002 – 1367.009.
17. H&S section 1367.010 – 1367.012.
18. H&S section 1367.02.
19. H&S section 1367.035.
20. H&S section 1367.042.
21. H&S section 1367.07 – 1367.1
22. H&S sections 1367.45 – 1367.46.
23. H&S section 1367.15.
24. H&S section 1367.23.
25. H&S section 1367.30.
26. H&S section 1368.2
27. H&S sections 1368.04 – 1368.05.
28. H&S section 1372.
29. H&S section 1373.5.
30. H&S sections 1373.621 – 1373.622.
31. H&S section 1373.7 – 1373.8.
32. H&S section 1373.95.
33. H&S section 1373.10.

34. H&S section 1373.14.
35. H&S section 1373.18.
36. H&S section 1374.
37. H&S sections 1374.5 – 1374.58.
38. H&S sections 1374.9 – 1374.10.
39. H&S, Article 5.5 of Chapter 2.2 of Division 2.
40. H&S, Article 5.55 of Chapter 2.2 of Division 2.
41. H&S sections 1374.65 – 1374.721.
42. H&S sections 1374.723 – 1374.76.
43. H&S sections 1375.1 – 1375.3.
44. H&S section 1376.
45. H&S section 1377.
46. H&S sections 1379.5 – 1380.
47. H&S section 1381.
48. H&S section 1383.
49. H&S section 1385.
50. H&S, Article 6.1 of Chapter 2.2 of Division 2.
51. H&S, Article 6.2 of Chapter 2.2 of Division 2.
52. H&S, Article 7 of Chapter 2.2 of Division 2.
53. H&S sections 1389.1 – 1389.7.
54. H&S, Article 8 of Chapter 2.2 of Division 2.
55. H&S, Article 8.5 of Chapter 2.2 of Division 2.
56. H&S sections 1395.6.H&S sections 1399.5.
57. H&S section 1399.57.
58. H&S, Article 10 of Chapter 2.2 of Division 2.
59. H&S, Article 10.2 of Chapter 2.2 of Division 2.
60. H&S, Article 11 of Chapter 2.2 of Division 2.
61. H&S, Article 11.1 of Chapter 2.2 of Division 2.
62. H&S, Article 11.5 of Chapter 2.2 of Division 2.
63. H&S, Article 11.8 of Chapter 2.2 of Division 2.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

1.0 Definitions

As used in this Exhibit L of this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms governs the construction of this ~~Contract~~ **Exhibit L. To the extent that definitions in this Exhibit L conflict with definitions in Exhibit A, Attachment I, Article 1.0 (*Definitions*), the definitions used in this Exhibit L apply here**:

~~**California Children Services (CCS) Provider** means any of the following Providers when used to treat Members for a CCS condition:~~

~~A. A medical Provider that is paneled by the CCS program, pursuant to Health and Safety Code (H&S), Article 5 (commencing with section 123800) of Chapter 3 of Part 2 of Division 106.~~

~~B. A licensed acute care hospital approved by the CCS program.~~

~~C. A special care center approved by the CCS program.~~

Specialized Durable Medical Equipment means **Durable Medical Equipment (**DME**)** that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a Physician's description and orders; is made to order or adapted to meet the specific needs of the beneficiary; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

2.0 EXHIBIT L OPERATIONAL READINESS DELIVERABLES AND REQUIREMENTS

	Operational Readiness Requirement
Exhibit L 1	Submit a written transition plan detailing the transfer of case management, Care Coordination, Provider referral, and service authorization administrative functions of the California Children's Services (CCS) program to Contractor to be prepared by the designated county agency and Contractor. The transition plan must include the following: 1) ~~Detailed process for completing all required risk assessments, including telephonic or in-person communications and, for CCS-eligible Members determined to be high risk, all required Individual Care Plans (ICPs) within one year for Whole-Child Model (WCM) transition Members.~~ **Details regarding the transfer of case management, Care Coordination, Provider referrals, and service authorization, including administrative functions, of the CCS Program to Contractor to be prepared by the designated county agency and Contractor.** 2) ~~Process for verifying that approved Subcontractors and Downstream Subcontractors that are delegated risk and are responsible for arranging for the provision of Covered Services are compliant. Refer to All Plan Letter (APL) 21-005 WCM Section: Risk Level and Needs Assessment Process for direction on required deliverable updates.~~ **Details regarding communications with Members regarding, but not limited to, authorizations, Network, case management, and ensuring continuity of care and services for Members who are in the process of aging out of CCS.** 3) ~~Detailed Dispute Resolutions Policy stating that disagreements between Contractor and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS. Refer to APL 21-005 WCM Section: Dispute Resolution and Provider Grievances for direction on required deliverable update.~~ **Details regarding the process for ensuring all WCM Members have access to a primary point of care who has knowledge or adequate training on the CCS Program and who is responsible for Care Coordination.**

Back to Agenda Back to Item

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

	4) Details regarding the process for completing all required pediatric risk assessments within 45 calendar days of the transition to determine Members' risk level, including telephonic or in-person communications. **5) A detailed process for completing all Individual Care Plans (ICPs) for WCM Members determined to be high risk within one year of the transition.** **6) A detailed process for verifying the compliance of Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.** **7) A detailed dispute resolutions policy setting out how disagreements between Contractor and the county CCS Program regarding CCS medical eligibility determinations must be resolved by the county CCS Program in consultation with DHCS, in compliance with the dispute resolution requirements in APL 23-034.** **8) Confirmation that Contractor will collaborate with the county CCS Program to provide input on the development of the transition plan.**
Exhibit L 2	Submit the executed WCM Memorandum of Understanding (MOU) or evidence indicating a reasonable effort to finalize the MOU with the county CCS program. Additionally, the MOU must address Contractor and **county** CCS **Program** coordination with regards to Medical Therapy Unit services.
Exhibit L 3	Submit a ~~Provider~~ network that includes an appropriate number of CCS Providers adequate to serve the needs of ~~CCS-eligible~~ **WCM** Members in the Service Area.
Exhibit L 4	Submit an updated Provider network via the Provider Network Readiness template. Contractor must complete and submit the provided template ~~and include~~ **as well as include any** additional contracted CCS-paneled Providers, allied and medical supportive personnel, Durable Medical Equipment (DME) Providers, and approved Provider facilities, including: Specialists, Tertiary and Pediatric Community Hospitals, ~~Neonatal Intensive Care Units,~~ and Special Care Centers. **Contractor must also include required outreach conducted to all out-of-Network Providers and facilities.**

Back to Agenda Back to Item

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

~~Exhibit L 5~~	~~Submit policies and procedures to ensure continuity of care for CCS-eligible Members with their CCS Providers, Specialized Durable Medical Equipment Providers, and Prescription Drugs.~~
Exhibit L ~~6~~**5**	Submit updated policies and procedures that outline Continuity of Care (COC) for CCS-Medically Necessary services~~, including the following:~~ **as set out in APL 23-034.** ~~1) COC for CCS-eligible Members to receive services outside of Contractor's Subcontractor if there is a WCM network certification deficiency within Contractor's Subcontractor Network.~~ ~~2) COC is allowed for CCS-eligible Members to continue to receive services from their previous DE, including their assigned PCP, for those who are required to select or be reassigned to a new DE.~~ ~~Contractor and its Subcontractors and Downstream Subcontractors must comply with COC requirements outlined in APL 22-032 and APL 21-005.~~ **These policies and procedures must describe in detail a process which allows Members to request and receive continuity of care with both existing CCS Provider(s) and Specialized DME Provider(s) for up to 12 months. The policies and procedures must outline how Contractor will ensure the WCM Members receive expert case management, Care Coordination, service authorization, and Provider referral services. The policies and procedures must outline Contractor's compliance with the continuity of care requirements identified in APL 23-022 and APL 23-034.**

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

Exhibit L ~~7~~**6**	Submit ~~Provider~~ network analysis to demonstrate the availability of an appropriate Provider network to serve the needs of ~~CCS Members~~ **WCM Members**, including Primary Care Providers (PCP), pediatric Specialists and sub-Specialists, professional, allied, and medical supportive personnel, licensed acute care hospitals, special care centers, and DME Providers. **This Network analysis must include an assessment of capacity, the existing Network and capabilities, the Providers available for contracting, a gap analysis, and a plan for closing those gaps. Contractor must, at a minimum, provide the following information in the analysis:** **1) Number of Members that Contractor expects to receive;** **2) Number of paneled / approved CCS Providers and facilities;** **3) Number of paneled / approved CCS Providers and facilities targeted for contracting; and** **4) The existing CCS/WCM Provider Network and its capacity to serve the expected Members.**
~~Exhibit L 8~~	~~Submit Contractor's standard, monthly 274 file(s) to the PACES production environment to confirm that the proposed Provider network supplied through the Provider Network Readiness template was realized via executed contracts, and the Provider network meets the needs of CCS Members.~~
Exhibit L ~~9~~**7**	Submit an attestation that Contractor and its Subcontractors and Downstream Subcontractors will work to execute contracts with all Providers included on the updated Provider Network Readiness template submission.

Back to Agenda Back to Item

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

Exhibit L ~~10~~**8**	Submit updated policies and procedures for ensuring Subcontractors and Downstream Subcontractors fully comply with all the terms and conditions of this Contract ~~with~~ **relating to** WCM network certification requirements including: 1) Policies and procedures for ensuring Subcontractors and Downstream Subcontractors meet WCM operational requirements included in ~~the contract~~ **this Contract,** as well as APL ~~21-005~~ **23-034**. 2) Process for ensuring a Subcontractor and Downstream Subcontractor meets WCM network certification requirements. 3) Oversight and readiness activities for Subcontractors and Downstream Subcontractors for Phase 2 to demonstrate requirements are met for implementation including: a) Subcontractor and Downstream Subcontractor Correspondence/Bulletins**;** b) Agendas and Meeting Notes regarding WCM**; and** c) Policies and Procedures ~~of~~ **setting out the compliance** review process for Subcontractors and Downstream Subcontractor**.** ~~4) Oversight and enhanced readiness activities for Subcontractors and Downstream Subcontractors for Phase 3 to demonstrate requirements are met for implementation including:~~ ~~a) Subcontractor and Downstream Subcontractor Correspondence/Bulletins~~ ~~b) Agendas and Meeting Notes regarding WCM~~ ~~c) Policies and Procedures review process for Subcontractors and Downstream Subcontractors.~~
Exhibit L ~~11~~**9**	Submit updated policies and procedures to ensure that credentialing and re-credentialing includes and speaks to CCS Providers.

Back to Agenda Back to Item

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

Exhibit L ~~12~~**10**	Submit **an** attestation that no ~~CCS-eligible~~ **WCM** Members will be enrolled or assigned to a Subcontractor and Downstream Subcontractor that is excluded from participating in WCM**,** and that Contractor will allow Members access to ~~CCS-paneled providers~~ **Providers** within all of Contractor's ~~Provider~~ network for CCS services. Provide process for how Contractor will ensure that that no ~~CCS-eligible~~ **WCM** Members will be enrolled or assigned to a ~~DE~~ **Subcontractor or Downstream Subcontractor** that is excluded from participating in WCM.
~~Exhibit L 13~~	~~Submit updated policies and procedures to include details surrounding the processes by which a CCS-eligible Member may maintain access to a Provider or a Specialized DME Provider for up to 12 months. The policy and procedure must endure the following:~~ ~~1) COC requirements for pharmaceutical services and the provision of prescribed drugs, as described in contract Exhibit A, Attachment III, Subsection 5.3.7.H (*Services for All Members*), are applied to CCS-eligible Members.~~ ~~2) Contractor must send a written notice to the Member 60 days before the 12-month authorization expires.~~ ~~3) Allow a CCS-eligible Member, or a family member or caregiver of a CCS beneficiary, to appeal the continuity of care 12-month limitation to the Director or their designee.~~

Back to Agenda Back to Item

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

Exhibit L ~~14~~**11**	Submit updated policies and procedures to explain the approach and development of ICPs for ~~CCS-eligible~~ **WCM** Members based on the results of the pediatric health risk assessment process. **Contractor must complete** ICPs ~~must be completed~~ with a particular focus on CCS specialty care, **must** consider behavioral health needs, and must coordinate those services. ~~If needed, Contractor must facilitate a CCS-eligible Member's ability to access appropriate community resources and other agencies, including referrals for behavioral services such as Specialty Mental Health Services and Substance Use Disorder services. The policies and procedures must include access for families to know where to go for ongoing information, education, and support so that they understand the goals, treatment plan, and course of care for their Child and their role in the process, what it means to have primary or specialty care for their Child, when it is time to call a PCP, Specialist, urgent care, or emergency room, what an interdisciplinary care team is, and what the community resources are.~~ ~~Risk Level and Needs Assessment. Refer to APL 21-005 WCM Section: Risk Level and Needs Assessment Process, for direction on required deliverable updates.~~ **The policies and procedures must state that if the Member or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives decline the development of an ICP, Contactor must notate the denial in the medical record as evidence of Contractor compliance.** **The policies and procedures must state that the ICP must incorporate, at a minimum, the Member's goals and preferences, and provide measurable objectives and timetables to meet the needs for the services listed in APL 23-034.** **The policies and procedures must state that the ICP must be developed by the case management team, in collaboration with the Member, the Member's parents, custodial parents, legal guardians, other Authorized Representatives, caregivers, or other authorized support persons, and must indicate the level of care the Member requires. The policies and procedures must also require that the ICP include all of the information listed in APL 23-034, as applicable.** **The policies and procedures must state that Contractor must reassess a Member's risk level and needs annually at the CCS**

Back to Agenda Back to Item

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

	eligibility redetermination or upon the report of a significant change to a Member's condition.
Exhibit L 12	**Provide summary of details regarding local stakeholder process with the meaningful engagement of a diverse group of families that represent a range of conditions, disabilities, demographics, and local Providers, including, but not limited to, the parent centers, such as family resource centers, family empowerment centers as well as parent training and information centers that support families in the particular county. Additionally, Contractor's summary must provide details on the meeting frequency of the CCS family advisory committee and CCS clinical advisory committee, which must meet at least quarterly in compliance with APL 23-034. Refer to the advisory committee requirements in APL 23-034 for direction on required deliverable updates.**
Exhibit L 13	**Submit updated policies and procedures as to the CCS maintenance and transportation benefit, in compliance with the transportation requirements as outlined in APL 23-034.** **If no updates to policies and procedures are needed, Contractor must submit an attestation stating that it reviewed the policies and procedures and no changes are necessary.**

Back to Agenda Back to Item

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

Exhibit L 14	**Submit updated policies and procedures including details regarding person-centered planning provided to WCM Members including details on CCS age-out planning responsibilities. Contractor must establish and maintain a process for preparing Members approaching CCS Program age limitations, including identification of Primary Care Providers (PCP) and specialty care Providers appropriate to the Members' CCS-Eligible Condition(s). Refer to requirements relating to age-out planning responsibilities in APL 23-034 for direction on required deliverable updates.**
Exhibit L 15	**Submit updated policies and procedures that include the mechanism by which WCM Members can request from Contractor a Specialist or clinic to serve as their Primary Care Provider.**
Exhibit L 16	**Submit updated policies and procedures describing the CCS clinical advisory committee and CCS family advisory committee, in compliance with W&I section 14094.17 and APL 23-034.**
Exhibit L 17	**Submit updated policies and procedures on how Contractor will inform WCM Members of how to access local family resource centers and family empowerment centers.**
Exhibit L 18	**Submit updated policies and procedures to ensure Contractor covers all Medically Necessary blood, tissue, and solid organ transplants, as defined by APL 21-015, for WCM Members, as outlined in the Medi-Cal Provider Manual.** **Contractor must refer WCM Members to a CCS-approved Special Care Center (SCC) for evaluation within 72 hours of the PCP or Specialist identifying the WCM Members' potential candidature for a blood, tissue, or solid organ transplant and receiving all of the necessary information to make a referral or authorization.** **Contractor must authorize the request for the blood, tissue, or solid organ transplant after the SCC confirms the Member is a suitable candidate for the blood, tissue, or solid organ transplant, in compliance with Health and Safety Code section 1367.01 and APL 21-015.** **If no updates are needed, Contractor must submit an attestation stating that its policies and procedures have been reviewed and no changes are necessary.**
Exhibit L 19	**Submit all WCM policies and procedures updates required by APL 23-034 that were not captured in the above deliverables.**

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

Exhibit L 20	**Submit updated policies and procedures that outline enhanced continuity of care policies applying to Members transitioning under the WCM expansion, as set out in APL 23-034.**

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

3.0 Whole Child Model Program

3.1 Whole Child Model Scope of Services
3.2 Required Reports for the Whole Child Model Program
3.3 Data Sharing Links
3.4 Whole Child Model Payments

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

3.1 Whole Child Model Scope of Services

3.1.1 Whole Child Model Program Compliance

In Orange County, Contractor ~~agrees to~~ **must** implement the Whole Child Model (WCM) program, as directed by DHCS and in accordance with **all WCM program requirements, including** Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016), **Assembly Bill (AB) 2724 (Arambula, Chapter 73, Statutes of 2022), AB 118 (Committee on Budget, Chapter 42, Statutes of 2023), and All Plan Letter (APL) 23-034,** in order to cover benefits that were previously covered by the California Children's Services (CCS) Program. Contractor's implementation of and participation in the WCM Program renders this Contract's requirements ~~around CCS~~, as stated in Exhibit A, Attachment III, Subsection 4.3.14 (*California Children's Services*), ~~and elsewhere in this Contract~~, inapplicable to Contractor.

A. Contractor must provide all Medically Necessary services previously covered by the CCS program as Covered Services for Members who are eligible for the CCS program at the time of the transition of benefits to Contractor, and for Members who are determined eligible for ~~CCS~~ **WCM** after the transition of benefits.

B. To ensure consistency in the provision of ~~covered~~ CCS **Covered Services**, Contractor must use all current and applicable CCS program guidelines, including CCS program **statutes,** regulations, CCS program information notices, and ~~CCS~~ numbered letters in developing criteria for use by Contractor's Medical Director or the equivalent, and other care management staff. When applicable CCS clinical guidelines do not exist, Contractor must use evidence-based guidelines or treatment protocols that are medically appropriate given the Member's CCS-eligible condition.

   The CCS numbered letters are posted by DHCS at the following web address for guidance on providing CCS Covered Services to **WCM** Members ~~eligible for CCS~~:

   http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

C. Contractor must ~~be responsible for~~ **provide** all available Medically Necessary Medi-Cal **Covered** Services. Any Medically Necessary CCS services not available as a Medi-Cal Covered Service must remain the responsibility of the State and the county.

Back to Agenda Back to Item

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

~~D. Contractor must submit its written transition plan to DHCS before commencing the transition to the Whole Child Model. The transition plan will detail how Contractor will transition CCS-eligible Members from the county CCS program to the Whole Child Model, and take over responsibility for case management, care coordination, Provider referrals, and service authorizations for Members who are enrolled in the CCS program at the time of the transition, in accordance with Health and Safety Code (H&S) section 123850(b)(1) and APL 21-005.~~

~~E~~**D**. Contractor must provide DHCS with documentation confirming that **Contractor has established** a local stakeholder process ~~has been established~~ in accordance with Welfare and Institutions Code (W&I) section 14094.7(d)(3). Such documentation may include meeting minutes, a meeting schedule, or other forms of confirmation approved by DHCS.

~~F~~**E**. Contractor must execute a MOU with the county CCS program as stipulated in Exhibit A, Attachment III, Subsection ~~5.6.1 (*MOU Purpose*)~~**5.6.3 (*MOU Oversight and Compliance*), and APL 23-034**, for the coordination of CCS services to Members. This MOU must include the following:

1) ~~Agreements on the transition of Care Coordination and service authorization for CCS from the county CCS program to Contractor, and how Contractor will work with the county CCS program to ensure continuity and consistency~~ **At a minimum, all of the provisions required in the WCM MOU template posted on the CCS WCM page of the DHCS website pursuant to W&I section 14094.9. If the Contractor or County CCS Program modifies any of the provisions of the WCM MOU Template, the Contractor must submit a redlined version of the MOU to DHCS for review and approval, prior to execution.**

2) ~~Policy~~ **A provision requiring policies** and procedures for referral to and coordination with the local CCS Medical Therapy Unit (MTU) to ensure appropriate access to MTU services, and other non-MTU services provided under this Contract;

3) A provision **requiring Contractor** to allow a **WCM** Member**,** ~~eligible for CCS to continue to receive care management and Care Coordination from their current CCS public health nurse, unless this requirement is waived by DHCS in accordance with W&I section~~

Back to Agenda Back to Item

~~14094.13(h). The Member~~ or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives, ~~must make the~~ **to** request to continue ~~with their current CCS~~ **case management and Care Coordination from their** public health nurse within 90 days of their transition to the ~~Whole Child Model~~ **WCM Program**, in accordance with W&I section 14094.13(e) and ~~(f)~~ **Subsection 3.1.9 (*Care Management and Coordination of Care*) of this Exhibit L**.

4) **Contractor must designate CCS Liaison(s) to be the primary point(s) of contact for the MOU and coordination of services between Contractor and county CCS Program. The CCS Liaisons must meet no less than quarterly to discuss activities related to the MOU and any other related matters. Contractor must submit to DHCS its designated CCS Liaison's contact information**.

5) **A provision requiring Contractor, at a minimum, to review its MOUs annually for any needed modifications or renewal of responsibilities and obligations outlined within. Contractor must submit to DHCS' Contract Manager evidence of the annual review of MOUs as well as copies of any MOUs modified or renewed as a result.**

F. **To the extent Contractor does not execute an MOU with the county CCS Program by the timeframe required by DHCS, Contractor must submit quarterly reports to DHCS documenting its continuing good faith efforts to execute the MOU, until such time as the MOU is executed. Documentation of good faith efforts must include a description of Contractor's attempts to execute an MOU and an explanation of why the MOU has not been executed.**

3.1.2 Annual Medical Eligibility Redeterminations

A. Contractor must provide all necessary documentation, dated within the last six months but no later than 12 months prior to the Member's CCS program eligibility end date to allow for an annual medical eligibility redetermination by the county CCS program **in accordance with 22 California Code of Regulations (CCR) section 41515.1 and APL 23-034**. This includes but is not limited to:

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

1) The Member's current medical records that document the Member's medical history;

2) Results of physical examinations by a ~~Physician~~ **physician's assistant, or nurse practitioner acting within the scope of their licensing authority**;

3) Laboratory test results;

4) Radiologic findings; ~~and~~ **or**

5) Other tests and examinations that support the diagnosis of the **CCS-**eligible condition(s), including any medical therapy unit diagnosis or high-risk infant follow-up reports.

B. Contractor must **provide the documentation, including efforts made to receive required documentation when it is not available to the independent County CCS Program, no later than 60 calendar days before the Member's program eligibility end date, unless the independent County CCS Program verifies that all needed medical information is already available to them** ~~no later than 60 calendar days before the Member's CCS Program eligibility end date~~. If documentation is received after the 60-day timeframe, Contractor **must notify and engage in a collaborative process with the County CCS Programs to remedy any issues or challenges related to the timeliness or completeness of records provided by the Contractor that are needed for the annual medical redetermination.**

C. If the county CCS program requires additional documentation, Contractor must, upon notification from the county CCS program, coordinate with the Member's Provider(s) to obtain any needed documentation, within the agreed upon timeframe, to support the county CCS program's medical redetermination efforts.

D. Contractor must proactively engage in a collaborative process with the county CCS program to remedy any issues or challenges related to timeliness or completeness of records for the medical eligibility redetermination process.

E. For disputes between Contractor and the county CCS program regarding CCS medical eligibility determinations where a resolution cannot be

Back to Agenda Back to Item

reached, Contractor may refer the dispute directly to DHCS for review and a final determination.

3.1.3 ~~CCS~~ WCM Advisory Committees

A. **In accordance with W&I section 14094.17(a) and APL 23-034,** Contractor must create and maintain a ~~CCS~~ **WCM** clinical advisory committee, separate and distinct from its Quality Improvement and Health Equity Committee described in Exhibit A, Attachment III, Section 2.3~~3~~**2** (*Quality Improvement and Health Equity Committee*). The ~~CCS~~ **WCM** clinical advisory committee must be composed of Contractor's **Chief** Medical ~~Director~~ **Officer** or the equivalent, the county CCS medical director, and at least four CCS-paneled Providers.

1) The ~~CCS~~ **WCM** clinical advisory committee must advise on clinical issues relating to CCS conditions, including treatment authorization guidelines, and to serve as clinical advisers on other clinical issues relating to CCS conditions.

2) The ~~CCS~~ **WCM** clinical advisory committee must meet at least quarterly, or more frequently if determined necessary.

B. **In accordance with W&I section 14094.17(b) and APL 23-034,** Contractor must establish a ~~CCS~~ **WCM** family advisory group that is separate and distinct from its Community Advisory Committee described in Exhibit A, Attachment III, Subsection 5.2.11.E (*Cultural and Linguistic Programs and Committees*), and is specifically for ~~CCS~~ **WCM** families.

1) The ~~CCS~~ **WCM** family advisory group must be comprised of ~~CCS-eligible~~ **WCM** Members' parents, custodial parents, legal guardians, or other Authorized Representatives. Family representatives who serve may receive a reasonable per diem payment to enable in-person participation in the ~~CCS~~ **WCM** family advisory group.

2) Contractor ~~may~~ **must** conduct ~~CCS~~ **WCM** family advisory group meetings at least quarterly and **may** utilize teleconference or other similar electronic means to facilitate participation.

3) A representative of the ~~CCS~~ **WCM** family advisory group must be invited to serve on the DHCS statewide stakeholder advisory group for CCS.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

3.1.4 CCS Provider Network

A. Contractor must include in their Network an adequate number of CCS Providers able to serve the needs of Members with CCS**-eligible** conditions and receive timely access. Contractor must utilize only paneled CCS Providers to treat CCS**-eligible** conditions when a ~~CCS-eligible~~ **WCM** Member's condition requires treatment from the Provider types described in this ~~Provision~~ **Exhibit L**. DHCS remains responsible for paneling CCS Providers. Contractor may use an out-of-state Provider, in accordance with APL 19-004, if an in-state CCS Provider does not possess the clinical expertise to appropriately treat the Member's CCS**-eligible** condition.

B. In addition to the Network requirements found in Exhibit A, Attachment III, Subsection 5.2.3 (*Network Composition*), Contractor must also include the following:

1) An adequate number of hospitals and/or facilities that include neonatal intensive care units, CCS-approved pediatric intensive care units, and CCS-approved inpatient facilities.

2) Licensed acute care hospitals and special care centers approved by the CCS program to treat a CCS-eligible condition.

3) That among the pediatric Network Providers are an adequate number of CCS-paneled Providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty.

C. In addition to the requirements in Exhibit A, Attachment III, Subsection 2.2.13 (*Credentialing and Recredentialing*), Contractor must credential CCS Providers in accordance with APL ~~21-005~~ **23-034**.

D. CCS Providers must be able to utilize Contractor's Provider Dispute Resolution Mechanism, as described in Exhibit A, Attachment III, Section 3.2.2 (*Provider Dispute Resolution Mechanism*).

3.1.5 Provider Compensation

In addition to the requirements found in Exhibit A, Attachment III, Section 3.3 (*Provider Compensation Arrangements*), Contractor must also reimburse Physicians and surgeons providing CCS to eligible Members at rates that are equal to or exceed the applicable CCS Fee-For-Service (FFS) rates, unless the

Back to Agenda Back to Item

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

Physician and surgeon enters into an agreement on an alternative payment methodology mutually agreed to by the Physician ~~and~~ **or** surgeon and Contractor.

3.1.6 Covered Services

In addition to the requirements found in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*), Contractor must cover CCS for Members determined to be eligible in accordance with ~~the CCS program medical eligibility regulations~~ **22 CCR section 51013**. Upon diagnostic evidence that a Member under 21 years of age may have a CCS-eligible condition, Contractor must refer the Member to the county CCS **program** office for eligibility determination.

A. Contractor must ensure assessment and Care Coordination for the transition of Members who are eligible for CCS and receiving services through the CCS program at the time of the transition, as required below in Exhibit L, Subsection 3.1.9 (*Care Management and Coordination of Care*).

B. For the identification of a Member eligible for CCS, Contractor must ensure the following:

1) Network Providers must perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that a Member has a CCS-eligible ~~medical~~ condition.

2) Initial referrals of Member's with **potential** CCS-eligible conditions must be made to the county CCS program by telephone, same day mail, or fax or other secure electronic system, if available. The initial referral must be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the county CCS program.

3) Contractor must provide all Medically Necessary CCS Covered Services for the Member's CCS-eligible condition(s).

4) If the county CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary Covered Services to the Member, including Early Periodic Screening, Diagnosis and Testing (EPSDT) as required in Exhibit

Back to Agenda Back to Item

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

A, Attachment III, Subsection 5.3.4. ~~F~~ **E** (*Services for Members Less Than 21 Years of Age*).

3.1.7 Continuity of Care

Contractor must provide continuity of care to ~~CCS-eligible~~ **WCM** Members transitioning to the ~~Whole Child Model Program~~ **WCM program** in accordance with W&I sections 14094.13, ~~H&S~~ **Health and Safety Code** section 1373.96, APL ~~21-005~~ **23-034**, and as follows:

A. In accordance with W&I section 14094.13(a)-(d), Contractor must ~~ensure~~ **establish and maintain a process for** continuity of care **for up to 12 months after the transition** between **WCM** Members ~~eligible for CCS~~ and CCS Providers, and ~~Providers of~~ Specialized Durable Medical Equipment **(DME) Providers**, with whom ~~there is an existing relationship for up to 12 months after the transition~~ **the WCM Member has an existing relationship**. **If Contractor and the Provider are unable to reach an agreement, Contractor must offer the Member an alternative Network Provider.**

B. For out-of-Network CCS Providers and ~~Providers of~~ Specialized ~~Durable Medical Equipment~~ **DME Providers**, Contractor must provide continuity of care under the following conditions**, as applicable**:

1) The Member has seen the **out-of-Network** CCS Provider for a non-emergency visit at least once during the 12 months immediately preceding their transition to the WCM program.

2) The Member has previously received Specialized ~~Durable Medical Equipment~~ **DME** from the **Specialized DME** Provider.

3) The CCS Provider or **Specialized DME** Provider ~~of Specialized Durable Medical Equipment~~ accepts Contractor's rate for the service, or the applicable Medi-Cal or CCS FFS rate, whichever is higher, unless the CCS Provider **or Specialized DME Provider** enters into an **agreement on an** alternative payment methodology mutually agreed upon by Contractor and the CCS Provider **or Specialized DME Provider**.

4) Contractor confirms that the CCS Provider meets applicable CCS standards and has no disqualifying quality of care issues.

Back to Agenda Back to Item

5) The CCS Provider makes treatment information available to Contractor, to the extent authorized by the State and federal patient privacy provisions.

6) The **Specialized DME** Provider ~~of Specialized Durable Medical Equipment~~ makes information available as requested by Contractor, to the extent authorized by the State and federal patient privacy provisions.

7) At its discretion, Contractor may extend the continuity of care period beyond the 12 months**, as** specified in Paragraph ~~C~~**B**.1) above.

C. Ensure that the continuity of care requirements for Pharmaceutical Services and Provision of ~~Prescribed~~ **Prescription** Drugs described in Exhibit A, Attachment III, Subsection 5.3.7.H (*Services for All Members*), are applied to Members who are eligible for the CCS program at the time of the transition to the WCM program. Before the previously prescribed ~~drug~~ **Prescription Drug** is discontinued, Contractor and the Member's prescribing CCS Provider must complete the necessary evaluation and treatments and must both agree that the previously prescribed ~~drug~~ **Prescription Drug** is no longer Medically Necessary, or that it is no longer prescribed by the Member's prescribing CCS Provider.

D. For CCS neonatal intensive care units, Contractor must pay the Provider either the equivalent of Medi-Cal FFS rates, such as the All Patient Refined Diagnosis Related Group (APR-DRG) rates or other established rates, or Contractor's negotiated rate, whichever is higher, for up to 12 months after the transition.

3.1.8 EPSDT Services

For ~~CCS-eligible~~ **WCM** Members, Contractor must provide all Medically Necessary Covered Services, including EPSDT services, as described in Exhibit A, Attachment III, Subsection 5.3.4.E (*Services for Members Less Than 21 Years of Age*), when the scope of an EPSDT benefit is more generous than the scope of a CCS benefit. In such cases, Contractor must apply the EPSDT standard of what is Medically Necessary to correct or ameliorate the Member's condition.

3.1.9 Care Management and Coordination of Care

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

In addition to the requirements in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*), and Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), Contractor must provide service authorization, case management, and Care Coordination for CCS ~~by~~ **through** a **CCS Case Manager, assigned as the** primary point of contact **for the Member,** with knowledge or adequate training on the CCS program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions. Once a Member's eligibility for the CCS program is established, Contractor must complete the following for risk stratification and assessment, and coordination of care in accordance with APL ~~21-005~~ **23-034**:

A. ~~For Members identified as eligible for CCS, Contractor must conduct a Risk Stratification and Segmentation (RSS) in accordance with the requirements in Exhibit A, Attachment III, Subsection 4.3.5 (*Population Risk Stratification and Segmentation, and Risk Tiering*), and approved by DHCS to use for CCS-eligible Members. Based on the results of the health risk stratification, Contractor must then further assess CCS-eligible Members' risk levels and needs with an in-person or telephone communication, or an additional risk assessment approved by DHCS.~~ **Contractor must designate at least one individual to serve as the CCS Case Manager. The CCS Case Manager will serve as the primary point of contact responsible for the provision of case management services and facilitation of Care Coordination for a Member receiving services through the WCM Program. The CCS Case Manager must have knowledge of or adequate training on the CCS Program and clinical experience with either the CCS population or pediatric patients with complex medical conditions. When WCM Members are eligible for and choose to receive Enhanced Care Management (ECM) services, Contractor may assign some or all CCS Case Manager functions to be delivered by ECM Providers as outlined DHCS' ECM Policy Guide. The CCS Case Manager should also be a point of contact for other care managers and service providers that serve WCM Members, including ECM Providers and Community Supports Providers.**

B. For the transition of Members who are eligible for CCS and receiving services through the CCS program at the time of the transition, Contractor must conduct a RSS in accordance with the requirements of this Contract.

C. ~~As determined necessary by Contractor's RSS, Contractor must provide Complex Care Management Services as described in Exhibit A,~~

Back to Agenda Back to Item

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

~~Attachment III, Subsection 4.3.7 (*Care Management Programs*), to all Members eligible for CCS and coordinate care between the Primary Care Provider (PCP), CCS specialty services, and if applicable Non-Specialty Mental Health Services and Regional Center services across all settings. The provision of Complex Care Management must include the facilitation of communication between the Member's health care Providers, personal care Providers such as IHSS, behavioral health Providers, and when appropriate, the Member and/or Member's parents, custodial parents, legal guardians, or other Authorized Representatives~~.

Contractor must assess Member eligibility for Complex Care Management (CCM) and Enhanced Care Management (ECM), as set out in Exhibit A, Attachment III, Subsection 4.3.7 (*Care Management Programs*), and coordinate enrollment into the most appropriate care management program to meet Member needs. A Member may not be enrolled in CCM and ECM at the same time.

A Member receiving CCS may also receive either CCM or ECM. When Members receive both CCS case management services and either CCM or ECM, Contractor must ensure coordination and non-duplication of CCS case management and CCM or ECM.

For Members receiving CCS case management and either CCM or ECM, the Contractor must provide coordination of care across all settings, including, but not limited to, between the Members' Primary Care Provider (PCP), CCS specialty services, and, if applicable, Non-Specialty Mental Health Services and Regional Center services.

D. Contractor must also arrange referral to Specialty Mental Health **Services** and Drug Medi-Cal services as appropriate through the county Substance Use Disorder (SUD) program if determined necessary through Contractor's RSS. To arrange services with a Regional Center, Contractor must:

1) Coordinate with **WCM** Members ~~eligible for CCS~~ and their parents, custodial parents, legal guardians, or other Authorized Representatives, in understanding and accessing services; and

2) Operate as a central point of contact for questions regarding access, care, and problem resolution.

Back to Agenda Back to Item

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

E. Contractor must create ~~a~~ **an Individual** Care ~~Management~~ Plan (~~CMP~~**ICP**) for ~~CCS-eligible~~ **WCM** Members who have been determined high risk through the RSS process, incorporate the required elements stated in W&I section 14094.11 and APL ~~21-005~~**23-034**, be specific to individual Member needs, and update the ~~CMP~~ **ICP** at least annually.

F. ~~Provide~~ **Contractor must provide** Person-Centered Planning, as described in Exhibit A, Attachment III, Subsection 5.2.12 (*Continuity of Care* ***for Seniors and Persons with Disabilities***), to **WCM** Members ~~eligible for CCS~~ and in collaboration with the Member's parents, custodial parents, legal guardians, or other ~~a~~**A**uthorized ~~r~~**R**epresentatives.

G. ~~Provide~~ **Contractor must provide** information to **WCM** Members ~~eligible for CCS~~ on how to access local family resource centers or family empowerment centers.

H. ~~Allow a Member eligible for CCS, or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives, to request continuing case management and Care Coordination from their public health nurse within 90 days of transitioning to the WCM program, in accordance with W&I section 14094.13(e). If the county public health nurse leaves the CCS program or is no longer available to provide case management and Care Coordination, Contractor must transition those services to one of its case managers who has received adequate training on the CCS program, and has clinical experience with the CCS population or pediatric patients with complex medical conditions.~~ **Contractor must provide continuing services with a county CCS Program Public Health Nurse:**

1) Contractor must allow a WCM Member, or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives, to request continuing case management and Care Coordination from their public health nurse within 90 calendar days of transitioning to the WCM program, in accordance with W&I section 14094.13(e).

2) Contractor must begin to process non-urgent requests for continuing public health nurse services within five Working Days of receipt of the request and complete the request within 30 calendar days of receipt. If the Member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs, Contractor must

Back to Agenda Back to Item

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

complete the request within 15 calendar days of receipt. If there is an identified imminent and serious threat to the health of the Member, Contractor must complete the request as soon as possible, but no longer than three calendar days of receipt.

3) **Contractor must make good faith efforts to reach a mutually agreeable financial arrangement for reimbursing the county CCS Program for continuing public health nurse services. If Contractor is unable to enter into such an arrangement, it must submit a waiver request to DHCS on the basis that reimbursement at the county CCS Program's proposed rate would result in substantially increased program costs. The waiver request will be subject to DHCS review and approval.**

4) **If the requested county public health nurse is no longer available to provide case management and Care Coordination, Contractor must transition those services to one of its CCS Case Managers who has received adequate training on the CCS Program and has clinical experience with the CCS population or pediatric patients with complex medical conditions.**

I. **For WCM Members, Contractor must conduct Risk Stratification and Segmentation (RSS), in accordance with the requirements in Exhibit A, Attachment III, Subsection 4.3.5 (*Population Risk Stratification and Segmentation, and Risk Tiering*), which is approved by DHCS for use with WCM Members. Based on the results of the RSS, Contractor must, as appropriate, further assess WCM Members' risk levels and needs with an in-person or telephone communication, or an additional risk assessment approved by DHCS.**

~~I~~**J**. If Contractor expands its CCS coverage area to other counties, Contractor must comply with CCS program standards including, but not limited to, referral standards as stated in W&I section 14093.06(a).

3.1.10 Rights for WCM Members ~~Eligible for CCS~~

A. Contractor must provide a mechanism for a **WCM** Member ~~eligible for CCS~~, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request a Specialist or clinic as a Primary Care Provider.

Back to Agenda Back to Item

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

B. For Members receiving continuity of care as stated in ~~Provision 5, Paragraph C~~ **Subsection 3.1.7 (*Continuity of Care)*** of this ~~Attachment~~ **Exhibit L**, Contractor must send a written notice 60 **calendar** days prior to the end of the authorized continuity of care period. The notice must explain ~~the right to~~ **that the Member may** petition Contractor for an extension of the continuity of care period, the criteria used to evaluate the petition, and the Appeals process if Contractor denies the petition.

C. In addition to the Member's right to file a Grievance or request an Appeal, State Hearing, or an Independent Medical Review if applicable, as stated in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*), Contractor must also ensure that **WCM** Members ~~who are eligible for CCS~~, or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives, may Appeal the continuity of care limitations, or the extension of a continuity of care period, as stated in this Exhibit L, Subsection 3.1.6 (*Covered Services*), to the DHCS Director in accordance with W&I section 14094.13(i)(1).

D. Contractor must also ensure that ~~CCS-eligible~~ **WCM** Members retain the right to request an Appeal and State Hearing for CCS eligibility and CCS service authorization denials.

3.2 Required Reports for the Whole Child Model Program

In addition to the reporting requirements for Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) stated in Exhibit A, Attachment III, ~~Section~~ **Article** 7.0.(*Operations Deliverables and Requirements*), Contractor must also identify which Grievances and requests for Appeal were submitted by ~~CCS-eligible~~ **WCM** Members.

3.3 Data Sharing Links

Contractor must establish and maintain communication links to allow interfaces with Children's Medical Services (CMS) Net and outside entities designated by DHCS.

3.3.1 Contractor must establish and maintain an agreement with the Office of Technology Services (O**T**~~t~~ech) within the California Department of Technology for an appropriate link between Contractor and O**T**~~t~~ech for the purpose of computer access for records contained in CMS Net and other Medi-Cal eligibility files that may be made available to Contractor. Upon connectivity with the authorized external entities, Contractor must retrieve information in a format to be determined by DHCS.

Back to Agenda Back to Item

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

3.3.2 Contractor must comply with all data sharing requirements in Exhibit G of this Contract.

3.4 Whole Child Model Payments

Contractor must be paid a supplemental WCM monthly payment for each **WCM** Member ~~who is determined eligible for CCS~~. Payments for **WCM** Members ~~identified as CCS-eligible~~ cannot exceed the rate as stated in Exhibit B, Section 1.3 (*Capitation Payment Rates*) and will be adjusted if DHCS has sent a separate rate payment for the **WCM** Member for the same month of service. The payment period for the supplemental WCM payment must commence on the effective date of this Contract, January 1, 2024.

3.4.1 Contractor must receive the supplemental WCM payment in accordance with the conditions listed below.

A. The supplemental WCM payment must be in lieu of any other compensation for a ~~CCS-eligible~~ **WCM** Member in any month.

B**.** Contractor must be eligible to receive a supplemental WCM payment in the month in which a ~~Member~~ **WCM Member's eligibility** is determined ~~to be eligible to receive CCS~~ by the county CCS program.

3.4.2 If DHCS determines that a Member for whom Contractor received a supplemental WCM payment was not determined eligible for CCS in the month(s) for which supplemental WCM payment was made, DHCS ~~must~~ **may** recover any amount improperly paid, by an offset to Contractor's capitation payment, in accordance with Exhibit B, ~~Section~~ **Subsection 1.**1.9 (*Recovery of Amounts Paid to Contractor*). DHCS must give Contractor **at least** 30 calendar days prior written notice of any such offset.

Back to Agenda Back to Item

CalOptima Health

CY 2024-C Contract Amendment Detail

Category	Requirement	Regulatory and Sub-Regulatory Guidance
Aid Codes (p. 29)	-Adds E8 as a mandatory covered aid code.	
Medical Loss Ratio (MLR) (pp. 93, 99)	-Updated MLR requirements regarding the expenditures that must be included in incurred claims and MLR reporting requirements.	APL 24-018: Medical Loss Ratio Requirements for Subcontractors and Downstream Subcontractors
Medical Authorization Timeframes (p. 160)	-Updated the authorization response time for Physician Administered Drugs (PADs) to 24 hours from receipt of the request.	
Managed Care Liaisons (pp. 256 – 257)	Incorporates further detail regarding the roles and responsibilities of the California Children's Services (CCS) Liaison.	APL 24-015: California Children's Services Whole Child Model Program
Member Information (p. 356)	Requires managed care plans (MCPs) to include information regarding minor consent requirements in the member handbook.	APL 24-019: Minor Consent to Outpatient Mental Health Treatment or Counseling
Network Certification Reports (pp. 370 – 371)	-MCPs must ensure provider participation in timely access surveys and network adequacy activities conducted by DHCS and must include provider participation language in Network Provider, Subcontractor, and Downstream Subcontractor Agreements. -MCPs must provide documentation demonstrating efforts to recruit new providers to areas that do not meet time or distance standards without the use of an Alternative Access Standards (AAS) request.	APL 23-001: Network Certification Requirements APL 25-006: Timely Access Requirements
Special Contract Provisions Related to Payment (pp. 524 – 525)	-Adds Children's Hospital Supplemental Payment (CHSP) and Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM).	
Whole Child Model (WCM) Scope of Services (pp. 685 – 699)	-Includes revisions to various WCM requirements such as WCM Memorandum of Understanding (MOU), liaisons, annual medical eligibility redeterminations, continuity of care, care management, and coordination of care.	APL 24-015: California Children's Services Whole Child Model Program

Back to Agenda Back to Item

Miscellaneous Updates	-Updated terms and acronyms used in the agreement. -Updated regulatory and APL citations. -Clarified and corrected language as necessary. -Updated Exhibit A, Attachment III – 7.0: Operations Deliverables and Requirements	

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 7, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Authorize the Chief Executive Officer to Negotiate and Execute a Contract with OpenText for a Cloud-based Faxing Solution

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Kathleen Linder, Chief Information Officer, (714) 475-9291

Recommended Action

1. Make an exception to CalOptima Health Policy GA.5002: Purchasing and authorize the Chief Executive Officer to negotiate and execute a contract without competitive procurement with OpenText for a Cloud-based faxing solution.
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $211,000 from the unspent Fiscal Year 2024-25 Digital Transformation Operating Budget to fund the contract with OpenText from September 1, 2025, through June 30, 2026.

Background and Discussion

CalOptima Health currently uses the OpenText RightFax solution to support automated faxes primarily for delivery of utilization management authorization and referral communications to providers. The RightFax contract has been in place since 2014. RightFax is an on-premises application.

Upgrading the current fax system is required to address security issues, provide disaster recovery, reduce costs, advance CalOptima Health's Cloud migration strategy, and avoid the lengthy transition time and risk associated with moving to another vendor/product.

1. **Security Issue Remediation**: The current RightFax solution relies on a legacy telephony platform, Avaya, which must be decommissioned due to security issues. Avaya cannot be decommissioned until CalOptima Health migrates off its on-premises RightFax application.
2. **Disaster Recovery Availability**: A Cloud-based faxing solution offers disaster recovery that is lacking in the current, on-premise solution.
3. **Cost Reduction**: In the health plan industry, there are two leading vendors in the electronic faxing space, OpenText and Concord. Moving to Concord would require an additional $400,000 in one-time costs for implementation, integration, and testing (versus upgrading the existing OpenText solution). The experience of other health plans indicates that moving to Concord does not reduce the ongoing cost of this application.
4. **Cloud Migration Strategy**: As CalOptima Health progresses in its strategy to migrate to the Cloud, it will upgrade many of its applications from the on-premises version to the Cloud-native version. This change is an example of this Cloud upgrade process; CalOptima Health is upgrading the OpenText on-premises solution to the OpenText Cloud-based application.
5. **Transition Time and Risk Optimization**: Moving to a new solution will require considerable time to implement, integrate, and test the solution. In addition, introducing a new solution increases the risk that prior authorization turnaround time could be impacted, impacting member care.

Back to Agenda

CalOptima Health Policy GA.5002: Purchasing outlines the processes for the procurement of goods and services essential to the operations of CalOptima Health. Competitive procurement is the required purchasing method unless competition is not feasible due to an emergency, restricted availability of goods or services, or other circumstances that would justify waiving the competitive requirements or the acquisition qualifies for another exception under the policy. Staff recommends that the CalOptima Health Board of Directors (Board) authorize an exception to the policy due to the circumstances described above to negotiate and execute a new contract with OpenText for a Cloud-based faxing solution without competitive bidding. The recommended action will eliminate security vulnerabilities, provide disaster recovery capabilities, reduce costs, advance CalOptima Health's Cloud strategy, and minimize transition time and risk.

Fiscal Impact

Capital Expenses

The estimated total capital expenses related to the new contract with OpenText are $389,000, for the period of September 1, 2025, through June 30, 2026. The CalOptima Health Fiscal Year (FY) 2022-23, 2023-24, 2025-26 Digital Transformation Capital Budgets have budgeted funds of $178,000 remaining for the capital project, "On-Premise Fax Server Replacement to a Supported Digital Cloud Fax Solution."

An appropriation of up to $211,000 from the unspent FY 2024-25 Digital Transformation Operating Budget will fund the remaining amount for the OpenText contract through June 30, 2026.

Operating Expenses

The FY 2025-26 Digital Transformation Strategy Operating Budget includes sufficient budgeted funds to support the recurring costs of approximately $190,000 for the OpenText contract from September 1, 2025, through June 30, 2026. The estimated annual fiscal impact is $230,000. Staff will include operating expenses for subsequent contract years in future operating budgets.

Rationale for Recommendation

The current faxing solution meets the needs of CalOptima Health. Upgrading (rather than replacing) the system delivers improved security and disaster recovery; reduces costs, advances CalOptima Health's Cloud migration strategy, and optimizes transition time and risk.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *07/31/2025*
Authorized Signature **Date**

Back to Agenda

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
OpenText	2440 Sand Hill Road, Suite 302	Menlo Park	CA	94025

Back to Agenda Back to Item

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 7, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

9. Approve Actions Related to Covered California Administrative Services Agreements

Contact

Donna Laverdiere, Executive Director, Strategic Development (714) 986-6981

Recommended Actions

1. To support the Department of Managed Health Care licensure filing process, authorize the Chief Executive Officer, or designee, to negotiate and execute contract amendments with specified vendors to update contract terms, as necessary, to include expanding services to the Covered California line of business, contract duration, payment terms, and regulatory requirements.

Background

On October 3, 2024, the CalOptima Health Board of Directors (Board) directed the Chief Executive Officer to request the Orange County Board of Supervisors (BOS) amend CalOptima Health's enacting ordinance to remove the prohibition on participation in Covered California. On January 14, 2024, the BOS approved an amended ordinance to allow CalOptima Health to pursue a contract with Covered California.

On June 5, 2025, the Board authorized the Chief Executive Officer to initiate, submit, and complete a filing with the Department of Managed Health Care (DMHC) to expand CalOptima Health's current Knox-Keene Act license to operate a Covered California health plan. On June 16, 2025, CalOptima Health submitted the initial filing to DMHC to expand the scope of CalOptima Health's current Knox Keene Act license to enable CalOptima Health to offer a Covered California product.

The DMHC filing is a multi-phased process that CalOptima Health must complete by early 2026 to offer the Covered California product for benefit plan year 2027. The process requires the submission of many supporting exhibits that demonstrate compliance with the requirements of the Knox-Keene Act. Requirements include filing fully executed Administrative Service Agreements for vendors that will perform services for CalOptima Health's Covered California line of business.

Discussion

As part of CalOptima Health's delivery of services in the Covered California line of business, CalOptima Health proposes using current vendors who provide administrative services to create continuity in service and streamline administrative operations. CalOptima Health must submit administrative services contracts related to its proposed Covered California line of business to DMHC as part of the licensure review process. CalOptima Health must amend several administrative services contracts before submitting them to DMHC to ensure their duration includes the launch of the Covered California product in 2027 and that the scope includes the performance of activities for the Covered California line of business.

Amending Scopes of Work for Administrative Services Contracts

Back to Agenda

CalOptima Health needs to add the Covered California line of business into the scope of work and Covered California and DMHC-required regulatory requirements into the contract terms to each of the below administrative services contracts. These contracts are for administrative services such as printing, language translation and interpretation, and quality data auditing services. The amendments needed to these contracts include the addition of Covered California as a program for which services would be provided, incorporation of Covered California and DMHC as regulators of the program, and associated regulatory requirements. The current terms for these vendor contracts extend beyond the start of the Covered California program at CalOptima Health and do not require extension.

Translation and Interpretation Vendors

Vendor	Administrative Service	Current Contract Termination Dates
Avantpage	Translation Services	02/28/2028 plus two one-year extensions
Big Language Solutions	Translation & Interpreting Services	02/28/2028 plus two one-year extensions
Hanna Interpreting Services LLC	Face-to-Face Interpreting Services and Face-to-Face Interpretation for American Sign Language	02/28/2028 plus two one-year extensions
Language Line Services, Inc.	Translation, Telephonic Interpretation, Face-to-Face Interpretation, and Video Interpretation	02/28/2028 plus two one-year extensions
Voiance Language Services, LLC	Telephonic and Video Interpreting Services	02/28/2028 plus two one-year extensions

Print and Fulfillment Vendors

Vendor	Administrative Service	Current Contract Termination Dates
Comprehensive Print Group LLC, dba Westprint	Print, Fulfillment and Direct Mail	05/30/2027 plus two one-year extensions
iColor Printing & Mailing Inc.	Print, Fulfillment and Direct Mail	05/30/2027 plus two one-year extensions
Sapphire Information, LLC	Print, Fulfillment and Direct Mail	05/30/2027 plus two one-year extensions
The Dot Corporation	Print, Fulfillment and Direct Mail	05/30/2027 plus two one-year extensions

HEDIS Data Auditing Services

Vendor	Administrative Service	Current Contract Termination Dates
Advent Advisory Group, LLC	HEDIS Compliance Audit Services	08/26/2027 plus two one-year extensions

Adding Covered California and Extending Contract Term

Back to Agenda

There are two administrative services contracts that require an extension to the contract term to ensure that the services are available in alignment with the launch of the Covered California product in January 2027. For those two contracts, CalOptima Health is proposing adding services for the Covered California line of business and associated Covered California and DMHC-regulatory requirements, and single-year contract extensions to ensure the services are available for the start of the benefit plan year 2027.

Vendor	Administrative Service	Current Contract Termination Dates	Proposed Amendment
Health Management Systems, Inc.	Third-Party Liability and Subrogation Recovery Services	09/30/2025 plus one-year extension	Extend contract term for one additional option year to 09/30/2027; add Covered CA line of business and associated requirements
Lexis Nexis – Enclarity	Software to verify Provider exclusions	10/31/2026	Extend contract term for one additional year to 10/31/2027; add Covered CA line of business and associated requirements

In the event an administrative services contract included in this Board action is terminated prior to the effectuation of the provisions related to the addition of the Covered California line of business, staff will provide an update to the Board.

Fiscal Impact
The recommended actions have no additional impact on the current fiscal year. Funding for the contract amendments will be included in future Covered California budgets or requested through separate Board actions.

Rationale for Recommendation
The above recommended actions will support CalOptima Health's requirement to file all administrative services agreements with DMHC in a timely fashion and ensure continuity of services during implementation of the new Covered California product.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action

/s/ Michael Hunn *07/31/2025*
Authorized Signature **Date**

Back to Agenda

Attachment to the August 7, 2025, Board of Directors Meeting – Agenda Item 9

Covered California Administrative Services Agreements

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Advent Advisory Group, LLC	PO Box 94	Northport	NY	11768
Avantpage	132 E. Street, Suite 370	Davis	CA	95616
Big Language Solutions	700 N. Brand Blvd., Suite 950	Glendale	CA	91203
Comprehensive Print Group LLC, dba Westprint	675 N. Main St.	Orange	CA	92868
Hanna Interpreting Services LLC	10783 Jamacha Blvd., Suite 8	Spring Valley	CA	91978
Health Management Systems, Inc.	5615 High Point Drive	Irving	TX	75038
iColor Printing & Mailing Inc.	13000 S. Broadway	Los Angeles	CA	90061
Language Line Services, Inc.	1 Lower Ragsdale Dr., Bldg. 2	Monterey	CA	93940
Lexis Nexis – Enclarity	16815 Von Karman, Suite 125	Irvine	CA	92606
Sapphire Information, LLC	3800 N. 38th Avenue	Phoenix	AZ	85019
The Dot Corporation	2424 McGaw Avenue	Irvine	CA	92614
Voiance Language Services, LLC	2650 E. Elvira Road	Tucson	AZ	85756

Back to Agenda Back to Item

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 7, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
10. Approve Modifications to the CalOptima Health Capitalization Policy

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

Recommended Action
Approve modifications to the CalOptima Health Policy GA.3301: Capitalization Policy

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

Discussion
The CalOptima Health Board of Directors (Board) last approved modifications to this policy on December 5, 2024. The Policy provides clear and uniform guidance for determining the proper classification of an asset and establishes policies and procedures to classify and capitalize assets owned or leased by CalOptima Health.

The table below outlines a list of substantive changes to GA.3301: Capitalization Policy, that are reflected in the attached redline policy. The list does not include non-substantive changes that may also be reflected in the redline, such as formatting, spelling, punctuation, capitalization, minor clarifying language, or grammatical changes.

Section	Proposed Change	Rationale
II.D.3	Revises language to clarify applicable accounting standards in accordance with Governmental Accounting Standards Board (GASB) 51 to expand the remaining life available for depreciating post-implementation enhancements or to upgrade phases of software development to include all contract renewal options	To address applicable accounting standards
V.A	Adds reference to GASB 51: June 2007 Accounting and Financial Reporting for Intangible Assets	To address applicable accounting standards

Fiscal Impact
The recommended action will have a minimal fiscal impact to the CalOptima Health Fiscal Year 2025-26 Capital and Operating Budgets. Staff anticipates the policy update may increase capitalized assets and depreciation expenses and decrease other non-salary expense accounts. Staff will monitor the impact of this policy update and, if necessary, bring any material items to a future Board meeting.

Back to Agenda

Rationale for Recommendation
Updates to the policy will ensure compliance with applicable accounting standards.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Health Policy GA.3301: Capitalization Policy

/s/ Michael Hunn *07/31/2025*
Authorized Signature **Date**

Back to Agenda

Policy:	GA.3301
Title:	**Capitalization Policy**
Department:	Finance
Section:	Accounting
CEO Approval:	*/s/*
Effective Date:	11/01/2011
Revised Date:	08/07/2025
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250807 BOD Review Only

I. PURPOSE

To provide clear and uniform guidance for determining the proper classification of an Asset and establish policies and procedures to classify and Capitalize Assets owned or leased by CalOptima Health.

II. POLICY

A. CalOptima Health shall establish a consistent process to classify and Capitalize Capital Assets that meets the Capitalization Threshold. Capital Assets shall be amortized or depreciated on a Straight-line Method.

B. CalOptima Health shall value new purchases, additions, and replacements at Cost, where Cost includes freight, installation, taxes, and other charges incurred to place the Asset in service.

C. CalOptima Health shall Capitalize major Building structural components, subsystems, and equipment separately based on their Asset class.

D. CalOptima Health shall Capitalize certain Costs associated with Internally Developed and Purchased Commercial Software.

1. CalOptima Health will expense internal and external Costs incurred during the Preliminary Project Stage of Software Development.

2. CalOptima Health shall Capitalize internal and external Costs incurred during the Application Development Stage of Software Development.

3. CalOptima Health shall generally expense internal and external Costs incurred during the Post-Implementation Project Stage of Software Development.

   a. The Accounting Department shall review Costs incurred during this stage for enhancements or upgrades that result in ~~new functionality, modules, and/or software capability for Capitalization. These Costs will be Capitalized over the remaining useful life of the original project.~~the following:

Back to Agenda Back to Item

i. New functionality (able to perform tasks that it was previously incapable of performing);

ii. Increased efficiency (increase in level of service provided without the ability to perform additional tasks; or

iii. Extension of the estimated useful life.

b. These Costs will be Capitalized and depreciated over the lesser of the new extended life or the current depreciable life for the software, not to exceed the base contract plus extensions, as long as there is intent to seek and ability to achieve contract renewal.

4. CalOptima Health shall cease Capitalization of Internally Developed Software no later than the point at which a computer software project is substantially complete and ready for its intended use, and after all substantial testing is complete, even if not yet launched to users.

5. Charges for licensing and monthly vendor maintenance or hosting during all stages of development are expensed in the corresponding month of service.

6. CalOptima Health shall Capitalize Costs to develop or obtain software that allows for access to or conversion of old data by new systems.

E. CalOptima Health shall classify all leases in which CalOptima Health is a lessee as a contract financing that conveys the right to use another entity's tangible Asset as specified in the contract for a period of time in an exchange or exchange-like transaction in accordance with Governmental Accounting Standards Board (GASB) 87 as defined in the June 2017 No. 366 Governmental Accounting Standards Series with a retroactive adoption date of June 15, 2021.

F. CalOptima Health shall Capitalize Assets with component Costs that are less than the Capitalization Threshold for an individual Asset, when the Asset in aggregate is equal to, or greater than the Capitalization Threshold as defined in Section III.A.

G. CalOptima Health shall establish an intangible Subscription Based Information Technology Arrangements (SBITA) and subscription liability for any qualifying GASB Statement 96, SBITA with a retroactive adoption date of June 15, 2022.

III. PROCEDURE

A. CalOptima Health shall Capitalize Assets used in operations with an initial useful life extending beyond one (1) year that also meets the Capitalization Threshold of twenty-five thousand ($25,000) dollars. The Accounting Department shall enter Capitalized and Controllable Assets into the Fixed Asset module of the accounting software system. The Accounting Department shall calculate depreciation using the Straight-line Method effective the first (1st) day of the subsequent month the Asset was placed in service.

B. The Accounting Department shall reclassify assembled Fixed Assets from Construction In Progress (CIP) to a depreciable Fixed Asset when construction is complete and meets the Capitalization Threshold. The Fixed Asset Cost is the sum of the construction components.

C. Categories and useful lives of Capitalized Assets shall be as follows:

For 20250807 BOD Review Only

Categories	Useful Lives
Furniture, fixtures, equipment	5 years
Vehicles	5 years
Hardware and Software:	
Computers/Printers	3 years
Software – Internal development Costs	Based on development stage
Software – Commercial	3 years
Land, Buildings, and Improvements:	
Land	Not depreciated
Buildings	40 years
Improvements:	
Building Components:	Based on Components:
Building shell	30 years
Electrical and lighting systems	20 years
Elevator systems	20 years
Fire protection systems	20 years
Fixed equipment	20 years
Floor coverings	15 years
Heating, ventilation, cooling	15 years
Interior finish	15 years
Misc. construction features	15 years
Plumbing systems	20 years
Roof coverings	10 years
Land Improvements:	Based on Improvement:
Fencing, brick, stone	25 years
Fencing, chain link, guardrails	15 years
Landscaping	10 years
Parking lot, open wall	20 years
Paving, asphalt	8 years
Water, sewer lines	20 years
Leasehold Improvements	The lesser of 15 years or the remaining term of lease
Tenant Improvements	The lesser of 7 years or the remaining term of lease

For 20250807 BOD Review Only

1. The Accounting Department may adjust Asset lives as necessary depending on the present condition and use of the Asset and based on how long the Asset is expected to meet current service demands.

D. The Accounting Department shall determine expenditures to Capitalize Buildings as follows:

1. Purchased Buildings

a. Original purchase price;

b. Expenses for remodeling, reconditioning, or altering a purchased Building to make it ready to use for the purpose for which it was acquired;

c. Environmental compliance including, but not limited to, asbestos abatement;

d. Professional fees including, but not limited to, architect, engineer, management fees for design and supervision, and legal services;

e. Payment of unpaid or accrued taxes on the Building to date of purchase;

f. Cancellation or buyout of existing leases; and

g. Other Costs required to place or render the Asset into operation.

2. Constructed Buildings

a. Completed project Costs;

b. Interest accrued during construction;

c. Cost of excavation, grading or filling of land for a specific Building;

d. Expenses incurred for the preparation of plans including, but not limited, specifications and blueprints;

e. Cost of Building permits;

f. Professional fees including, but not limited to, architect, engineer, management fees for design and supervision, and legal services;

g. Costs of temporary Buildings used during construction;

h. Permanently attached fixtures or machinery that cannot be removed without impairing the use of the Building;

i. Additions to Buildings including, but not limited to, expansions, extensions, and enlargements; and

j. Unanticipated Costs allowable by GASB.

E. CalOptima Health shall calculate and record Capital Leases for tangible Assets according to the following:

1. A materiality threshold of twenty-five thousand ($25,000) dollars for one (1) year of payments;

2. For those that meet the materiality threshold, the net present value of the sum of the contract's fixed payment schedule at commencement is recorded as a Capital Lease Asset and lease liability;

3. If the contract terms include options to extend or terminate, then these are included in the contract sum when it is reasonably certain that they will be exercised; and

4. The prime rate of interest is used when determining the net present value.

For 20250807 BOD Review Only

F. CalOptima Health shall record an intangible Asset for a SBITA Arrangement when:

1. The contract conveys control of the right to use another entity's nonfinancial Asset (the underlying Asset) as specified in the contract for a period of time in an exchange or exchange-like transaction;

2. The contract is cancellable for cause;

3. The contract does not transfer ownership of the underlying Asset;

4. The underlying Asset is used to conduct CalOptima Health business;

5. The annual contract Costs are fifty thousand ($50,000) dollars or above based on the informal Micro Purchase limit, pursuant to CalOptima Health Policy GA.5002: Purchasing;

6. The minimum contract is greater than twelve (12) months;

7. If the contract terms include options to extend or terminate, then these are included in the contract sum when it is reasonably certain that they will be exercised; and

8. The prime rate of interest is used when determining the net present value.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Governmental Accounting Standards Board (GASB) No. 51; June 2007 Accounting and Financial Reporting for Intangible Assets

~~A.~~B. Governmental Accounting Standards Board (GASB) No. 87; June 2017 No. 366 Governmental Accounting Standards Series

~~B.~~C. Governmental Accounting Standards Board (GASB) No. 96; June 2022

~~C.~~D. CalOptima Health Policy GA.5002: Purchasing

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/03/2022	Regular Meeting of the CalOptima Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors
08/07/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2011	GA.3301	Capitalization Policy	Administrative
Revised	03/03/2022	GA.3301	Capitalization Policy	Administrative – Internal only
Revised	04/01/2023	GA.3301	Capitalization Policy	Administrative – Internal only

F 20250807 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	12/05/2024	GA.3301	Capitalization Policy	Administrative – Internal only
Revised	08/07/2025	GA.3301	Capitalization Policy	Administrative – Internal only

For 20250807 BOD Review Only

IX. GLOSSARY

Term	Definition
Application Development Stage of Software Development	The stage of software development related to the enhancement or upgrade of in-house or cloud-based software, including the design of the chosen path, software configuration and interfaces, labor, installation to hardware, testing, and parallel processing phase.
Asset	A tangible or intangible item of value.
Building	A structure that is permanently attached to the land, has a roof, is partially or completely enclosed by walls and is not intended to be transportable or moveable.
Capital	Financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Capital Asset	Any asset used in operations with an initial useful life extending beyond one (1) year that also meets the Capitalization Threshold.
Capital Lease	A type of lease agreement where the lessee (the company or individual renting the asset) assumes the risks and rewards of ownership of the tangible leased asset. The lessee treats the leased asset as if they purchased and financed it through the lease agreement.
Capitalization	The recording of an item as an asset rather than an expense such that the expenditure will appear in the balance sheet.
Capitalization Threshold	The threshold for capitalized items is twenty-five thousand ($25,000) dollars.
Capitalize	To record an item as an asset rather than an expense such that the expenditure will appear in the balance sheet.
Controllable Assets	Certain purchases that do not meet the criteria established for designation as a Capital asset, however, by their nature should be monitored for proper use and disposal. These controllable assets either render a critical function or put the organization at risk by their absence. Such items include but are not limited to laptops, computers, printers, minor furnishings, and general office equipment.
Cost	Cost includes freight, installation, taxes and other charges incurred to place the asset in use. –Service and maintenance contracts are charged to prepaid expenses and amortized over the period of the contract.
Fixed Assets	Fixed assets or Capital assets are tangible assets with a value greater than or equal to the Capitalization Threshold and a useful life in excess of one (1) year. Fixed assets include buildings, machinery and equipment, computer equipment, vehicles, improvements, and land.
Micro Purchase	Purchase of goods, non-medical professional services, Public Works projects, capital projects, and computer equipment and telecommunications goods and services estimated to cost less than fifty thousand ($50,000) dollars.
Preliminary Project Stage of Software Development	The stage of software development related to the internal development of software that is new to the organization, which includes design and evaluations of alternatives.
Post-Implementation Project Stage of Software Development	All expenditures related to the post-implementation of internally developed software. Expenditures include application maintenance, labor, and training.
Software-Commercial	Commercially available software that requires minimal effort to put into operation. All expenditures related to the initial implementation (excluding equipment or hardware), totaling greater than the Capitalization Threshold, and to be used for more than one (1) year are capitalized.

For 20250807 BOD Review Only

Term	Definition
Software, Internally Developed	Software developed in-house by personnel or by a third-party contractor on behalf of CalOptima Health, or commercially available software purchased or licensed by CalOptima Health that has been modified to a significant degree before being put into use.
Straight-line Method	A method to record the allocation of an asset's cost evenly over its useful life.

1

For 20250807 BOD Review Only

Policy:	GA.3301
Title:	**Capitalization Policy**
Department:	Finance
Section:	Accounting
CEO Approval:	*/s/*
Effective Date:	11/01/2011
Revised Date:	08/07/2025
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250807 BOD Review Only

I. PURPOSE

To provide clear and uniform guidance for determining the proper classification of an Asset and establish policies and procedures to classify and Capitalize Assets owned or leased by CalOptima Health.

II. POLICY

A. CalOptima Health shall establish a consistent process to classify and Capitalize Capital Assets that meets the Capitalization Threshold. Capital Assets shall be amortized or depreciated on a Straight-line Method.

B. CalOptima Health shall value new purchases, additions, and replacements at Cost, where Cost includes freight, installation, taxes, and other charges incurred to place the Asset in service.

C. CalOptima Health shall Capitalize major Building structural components, subsystems, and equipment separately based on their Asset class.

D. CalOptima Health shall Capitalize certain Costs associated with Internally Developed and Purchased Commercial Software.

1. CalOptima Health will expense internal and external Costs incurred during the Preliminary Project Stage of Software Development.

2. CalOptima Health shall Capitalize internal and external Costs incurred during the Application Development Stage of Software Development.

3. CalOptima Health shall generally expense internal and external Costs incurred during the Post-Implementation Project Stage of Software Development.

   a. The Accounting Department shall review Costs incurred during this stage for enhancements or upgrades that result in the following:

      i. New functionality (able to perform tasks that it was previously incapable of performing);

Back to Agenda Back to Item

ii. Increased efficiency (increase in level of service provided without the ability to perform additional tasks; or

iii. Extension of the estimated useful life.

b. These Costs will be Capitalized and depreciated over the lesser of the new extended life or the current depreciable life for the software, not to exceed the base contract plus extensions, as long as there is intent to seek and ability to achieve contract renewal.

4. CalOptima Health shall cease Capitalization of Internally Developed Software no later than the point at which a computer software project is substantially complete and ready for its intended use, and after all substantial testing is complete, even if not yet launched to users.

5. Charges for licensing and monthly vendor maintenance or hosting during all stages of development are expensed in the corresponding month of service.

6. CalOptima Health shall Capitalize Costs to develop or obtain software that allows for access to or conversion of old data by new systems.

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F. CalOptima Health shall Capitalize Assets with component Costs that are less than the Capitalization Threshold for an individual Asset, when the Asset in aggregate is equal to, or greater than the Capitalization Threshold as defined in Section III.A.

G. CalOptima Health shall establish an intangible Subscription Based Information Technology Arrangements (SBITA) and subscription liability for any qualifying GASB Statement 96, SBITA with a retroactive adoption date of June 15, 2022.

III. PROCEDURE

A. CalOptima Health shall Capitalize Assets used in operations with an initial useful life extending beyond one (1) year that also meets the Capitalization Threshold of twenty-five thousand ($25,000) dollars. The Accounting Department shall enter Capitalized and Controllable Assets into the Fixed Asset module of the accounting software system. The Accounting Department shall calculate depreciation using the Straight-line Method effective the first (1st) day of the subsequent month the Asset was placed in service.

B. The Accounting Department shall reclassify assembled Fixed Assets from Construction In Progress (CIP) to a depreciable Fixed Asset when construction is complete and meets the Capitalization Threshold. The Fixed Asset Cost is the sum of the construction components.

C. Categories and useful lives of Capitalized Assets shall be as follows:

Categories	Useful Lives
Furniture, fixtures, equipment	5 years
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For 20250807 BOD Review Only

Categories	Useful Lives
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Elevator systems	20 years
Fire protection systems	20 years
Fixed equipment	20 years
Floor coverings	15 years
Heating, ventilation, cooling	15 years
Interior finish	15 years
Misc. construction features	15 years
Plumbing systems	20 years
Roof coverings	10 years
Land Improvements:	Based on Improvement:
Fencing, brick, stone	25 years
Fencing, chain link, guardrails	15 years
Landscaping	10 years
Parking lot, open wall	20 years
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Tenant Improvements	The lesser of 7 years or the remaining term of lease

1. The Accounting Department may adjust Asset lives as necessary depending on the present condition and use of the Asset and based on how long the Asset is expected to meet current service demands.

D. The Accounting Department shall determine expenditures to Capitalize Buildings as follows:

1. Purchased Buildings

   a. Original purchase price;

   b. Expenses for remodeling, reconditioning, or altering a purchased Building to make it ready to use for the purpose for which it was acquired;

For 20250807 BOD Review Only

Back to Agenda Back to Item

c. Environmental compliance including, but not limited to, asbestos abatement;

d. Professional fees including, but not limited to, architect, engineer, management fees for design and supervision, and legal services;

e. Payment of unpaid or accrued taxes on the Building to date of purchase;

f. Cancellation or buyout of existing leases; and

g. Other Costs required to place or render the Asset into operation.

2. Constructed Buildings

a. Completed project Costs;

b. Interest accrued during construction;

c. Cost of excavation, grading or filling of land for a specific Building;

d. Expenses incurred for the preparation of plans including, but not limited, specifications and blueprints;

e. Cost of Building permits;

f. Professional fees including, but not limited to, architect, engineer, management fees for design and supervision, and legal services;

g. Costs of temporary Buildings used during construction;

h. Permanently attached fixtures or machinery that cannot be removed without impairing the use of the Building;

i. Additions to Buildings including, but not limited to, expansions, extensions, and enlargements; and

j. Unanticipated Costs allowable by GASB.

E. CalOptima Health shall calculate and record Capital Leases for tangible Assets according to the following:

1. A materiality threshold of twenty-five thousand ($25,000) dollars for one (1) year of payments;

2. For those that meet the materiality threshold, the net present value of the sum of the contract's fixed payment schedule at commencement is recorded as a Capital Lease Asset and lease liability;

3. If the contract terms include options to extend or terminate, then these are included in the contract sum when it is reasonably certain that they will be exercised; and

4. The prime rate of interest is used when determining the net present value.

F. CalOptima Health shall record an intangible Asset for a SBITA Arrangement when:

For 20250807 BOD Review Only

1. The contract conveys control of the right to use another entity's nonfinancial Asset (the underlying Asset) as specified in the contract for a period of time in an exchange or exchange-like transaction;

2. The contract is cancellable for cause;

3. The contract does not transfer ownership of the underlying Asset;

4. The underlying Asset is used to conduct CalOptima Health business;

5. The annual contract Costs are fifty thousand ($50,000) dollars or above based on the informal Micro Purchase limit, pursuant to CalOptima Health Policy GA.5002: Purchasing;

6. The minimum contract is greater than twelve (12) months;

7. If the contract terms include options to extend or terminate, then these are included in the contract sum when it is reasonably certain that they will be exercised; and

8. The prime rate of interest is used when determining the net present value.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Governmental Accounting Standards Board (GASB) No. 51; June 2007 Accounting and Financial Reporting for Intangible Assets
B. Governmental Accounting Standards Board (GASB) No. 87; June 2017 No. 366 Governmental Accounting Standards Series
C. Governmental Accounting Standards Board (GASB) No. 96; June 2022
D. CalOptima Health Policy GA.5002: Purchasing

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/03/2022	Regular Meeting of the CalOptima Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors
08/07/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2011	GA.3301	Capitalization Policy	Administrative
Revised	03/03/2022	GA.3301	Capitalization Policy	Administrative – Internal only
Revised	04/01/2023	GA.3301	Capitalization Policy	Administrative – Internal only
Revised	12/05/2024	GA.3301	Capitalization Policy	Administrative – Internal only
Revised	08/07/2025	GA.3301	Capitalization Policy	Administrative – Internal only

FC 20250807 BOD Review Only

1
2

For 20250807 BOD Review Only

IX. GLOSSARY

Term	Definition
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Capitalization	The recording of an item as an asset rather than an expense such that the expenditure will appear in the balance sheet.
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Cost	Cost includes freight, installation, taxes and other charges incurred to place the asset in use. Service and maintenance contracts are charged to prepaid expenses and amortized over the period of the contract.
Fixed Assets	Fixed assets or Capital assets are tangible assets with a value greater than or equal to the Capitalization Threshold and a useful life in excess of one (1) year. Fixed assets include buildings, machinery and equipment, computer equipment, vehicles, improvements, and land.
Micro Purchase	Purchase of goods, non-medical professional services, Public Works projects, capital projects, and computer equipment and telecommunications goods and services estimated to cost less than fifty thousand ($50,000) dollars.
Preliminary Project Stage of Software Development	The stage of software development related to the internal development of software that is new to the organization, which includes design and evaluations of alternatives.
Post-Implementation Project Stage of Software Development	All expenditures related to the post-implementation of internally developed software. Expenditures include application maintenance, labor, and training.
Software-Commercial	Commercially available software that requires minimal effort to put into operation. All expenditures related to the initial implementation (excluding equipment or hardware), totaling greater than the Capitalization Threshold, and to be used for more than one (1) year are capitalized.

For 20250807 BOD Review Only

Term	Definition
Software, Internally Developed	Software developed in-house by personnel or by a third-party contractor on behalf of CalOptima Health, or commercially available software purchased or licensed by CalOptima Health that has been modified to a significant degree before being put into use.
Straight-line Method	A method to record the allocation of an asset's cost evenly over its useful life.

1

For 20250807 BOD Review Only

Continued to the September 4, 2025 Board Meeting

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 7, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

11. Approve Modifications to Policy GA.5004: Travel and Other Reimbursable Expenses

Contact

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

Recommended Action

Approve modifications to CalOptima Health Policy GA.5004: Travel and Other Reimbursable Expenses.

Background

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

Discussion

The CalOptima Health Board of Directors (Board) last approved modifications to this policy on November 2, 2023. The Policy provides guidance on reimbursable business-related expenses, including travel, transportation, catering and meals, lodging, professional licenses and membership dues, and public activities. Because this policy applies to Board members, standing committee members, employees, contractors, and others who conduct business on CalOptima Health's behalf, staff seeks Board approval of the proposed policy changes.

The table below outlines the substantive changes to Policy GA.5004 that are reflected in the attached redline policy. The list does not include non-substantive changes that may also be reflected in the redline (*i.e.*, formatting, spelling, punctuation, capitalization, minor clarifying language, or grammatical changes).

Section	Proposed Change	Rationale
II.C.1.d.ii	Removes section allowing remote teleworkers who began their workday at home to claim mileage reimbursement for travel to the central worksite.	Clarifies reimbursable mileage
II.C.2.c.i	Adds "CalOptima Health will reimburse up to 125% of the GSA rate. If the nightly rates differ, the average nightly rate for the stay's duration should be calculated to determine if it is within the 125% threshold."	Provides additional guidance on the maximum reimbursable lodging rates
II.C.2.c.ii	Adds "Lodging rates in excess of the 125% Federal GSA rate may be reimbursed with prior authorization from the CEO or CFO or if a conference provides a documented lodging discount as part of a group or advance booking, and this rate exceeds the 125% threshold."	Provides additional guidance on allowable exceptions to the previous section

Back to Agenda

Section	Proposed Change	Rationale
II.C.3.b	Increases the maximum reimbursement for travel meals from $80.00 to $92.00 per day.	Increases limit to account for the impact of inflation
II.E.1.a.i	Adds "does not include team building events or off-site social venues."	Clarifies items that are not eligible for meal reimbursements
III.B.2	Adds "Employees granted the exception to book their own airfare shall not use personal credit card points, as CalOptima Health does not reimburse for this method of booking."	Provides additional guidance on paying for travel arrangements

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The proposed changes to CalOptima Health Policy GA.5004: Travel and Other Reimbursable Expenses address pertinent changes, align policy with current operations, and provide greater clarity on reimbursable travel expenses and procedures.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Health Policy GA.5004: Travel and Other Reimbursable Expenses

/s/ Michael Hunn *07/31/2025*
Authorized Signature **Date**

Back to Agenda

CalOptima Health

Policy:	GA.5004
Title:	**Travel and Other Reimbursable Expenses**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/2012
Revised Date:	07/01/2025
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250807 BOD Review Only

I. PURPOSE

This policy establishes a uniform standard and process for reasonable and equitable reimbursement of approved travel, Transportation, catering and meals, lodging, business-related professional licenses and membership dues, public activities, and other actual and necessary business-related expenses incurred by CalOptima Health Employees, Governing Body, Standing Committee Members, and authorized contractors and consultants while conducting authorized CalOptima Health Business.

II. POLICY

A. CalOptima Health shall comply with all applicable laws and regulations to provide and reimburse Authorized Individuals for business-related expenses, which includes travel, Transportation, catering and meals, lodging, business-related professional licenses and membership dues, public activities, and other actual and necessary business-related expenses. The Finance Department shall implement an approval and reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel, Transportation, meals, lodging, and miscellaneous expenses incurred by Authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal laws and regulations.

B. CalOptima Health shall reimburse Authorized Individuals for reasonable, actual, and necessary expenses incurred while conducting CalOptima Health Business. Reimbursements for CalOptima Health business-related expenses shall be made in accordance with the Internal Revenue Service's (IRS) requirements, particularly the rules for an accountable plan, which requires: (1) expenses to have a business connection; (2) expenses be adequately accounted for within a reasonable period of time; and (3) any excess reimbursement or allowance be returned within a reasonable period of time. Reimbursement may be authorized when there is a clear connection or nexus between the attendance of the individual at such activity or function and the performance of official duties for which such an individual is regularly employed.

C. Business-related expenses for travel while conducting CalOptima Health Business 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, avoiding peak travel times, and leveraging efficiency by combining multiple meetings

Back to Agenda Back to Item

and events whenever possible. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible. Reimbursable travel expenses include actual and necessary expenses, such as:

1. Transportation: Including, but not limited to, commercial carriers, rental vehicles, mileage for use of personal vehicles, taxis, recognized ride-share companies, shuttles, and public transit fares.

    a. In selecting the mode of Transportation**,** the Authorized Individual shall consider 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.

    b. The Authorized 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.

        i. Authorized Individuals may, for personal convenience, travel to their final destination on an indirect route, or on an interrupted direct route, if approved in advance within the Travel and Training Authorization (TTA) form. An Authorized 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.

        ii. Additional expenses shall not be the responsibility of the Authorized Individual if, through no fault or control of the Authorized 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.

        iii. Whenever available, all Authorized 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, unless First or Business Class is shown to be cheaper than coach (proof of price is required for reimbursement).

        iv. Authorized 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.

        v. Any deviation from the lowest available rate for commercial carriers shall be at the Authorized Individual's expense.

    c. The Authorized Individual shall be responsible for necessary cancellation of travel reservations, in accordance with the respective ~~carrier's~~carriers' rules and time limits. CalOptima Health shall not reimburse Authorized Individuals for fees associated with the failure to cancel reservations within the established carrier's rules and time limits unless the failure was due to circumstances beyond the control of the Authorized Individual. The Authorized Individual must also inform the Procurement & Vendor Management Department of any such cancellations.

    d. Use of Privately-Owned Vehicles

For 20250807 POD Review Only

i. 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 Authorized Individual must be licensed and shall carry liability insurance as required by the State of California, at the Authorized Individual's sole expense.

ii. CalOptima Health shall reimburse the use of privately-owned vehicles solely based on actual mileage at the IRS Standard Mileage Rate at the time of travel. The Authorized Individual shall report ~~the~~ total mileage ~~and separately provide the offset mileage, which is~~reduced by the round-trip mileage distance between their ~~home~~residence and their CalOptima Health central worksite, except in the following situations:

a) If a teleworker is classified as a Community Worker by Human Resources, CalOptima Health shall reimburse for the round-trip mileage from the teleworker's remote work location to the off-site location~~;~~.

~~b) If a remote teleworker begins their business day at home, and then travels for member or provider business appointments or to the central worksite, CalOptima Health shall reimburse for the round-trip mileage from the teleworker's remote work location to the off-site location(s) (offset mileage is not required). Support for beginning the workday at home must be attached to the Expense Report;~~

~~c)~~b) If an Authorized Individual's scheduled workday begins and ends at the CalOptima Health central worksite, any required off-site travel during the day shall be reimbursed for the round-trip mileage from CalOptima Health's central worksite to the off-site location and back; or.

~~d)~~c) If an Authorized Individual is required to travel for a CalOptima Health function that occurs on a day where the Authorized Individual is not normally scheduled to work, CalOptima Health shall reimburse the round-trip mileage from the Authorized Individual's home to the CalOptima Health function's location.

iii. For Authorized Individuals who receive an automobile allowance pursuant to CalOptima Health Policy GA.8042: Supplemental Compensation, CalOptima Health will only reimburse actual mileage at the IRS Standard Mileage Rate for travel that exceeds a round-trip of 100 miles based on the distance of the final destination from the individual's primary worksite. Use of privately-owned vehicles within a round-trip of 100 miles or less per meeting or event based on the distance of the final destination from the individual's primary workplace is covered as part of the automobile allowance.

iv. CalOptima Health shall not reimburse costs for fuel, automobile repairs, other automobile expense items, or traffic/parking citations.

v. If more than one Authorized Individual is traveling for CalOptima Health Business in the same personal vehicle, only one person shall be reimbursed for the use of a privately-owned vehicle.

vi. Travel shall be by the most practical direct route. Any person traveling by an indirect route shall assume any additional expense incurred.

vii. CalOptima Health shall compensate property damages to an Authorized Individual's automobile incurred without fault or cause on the part of the Authorized Individual up

For 20250807 BOD Review Only

to two hundred fifty dollars ($250), or the amount of the deductible on the person's insurance policy, whichever is the lesser amount, for each accident.

e. Rental Automobiles

i. An Authorized Individual may rent an automobile when such rental is considered to be more advantageous to CalOptima Health than other means of Transportation.

ii. Advance reservations shall be made whenever possible. Reservations for the Authorized Individual and the vehicle rental agreement shall be made in the person's name, acting for CalOptima Health. i.e., John Doe, for CalOptima Health.

iii. Rental automobile approved classes are as follows:

a) Economy Class or equivalent: An Authorized Individual shall select an economy class vehicle whenever four (4) or fewer Authorized Individuals, including the driver, will be passengers in the rental automobile at any one time.

b) Mid-size Class or equivalent: An Authorized Individual may select a mid-size class vehicle in the event more than four (4) Authorized 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 or if the cost is lower than that of an economy class (Documented support required).

c) Luxury Class or equivalent: Under no circumstances shall an individual select a luxury class vehicle.

f. Other Modes of Transportation

i. Taxi Fares or Shuttles: CalOptima Health shall reimburse taxi fares or shuttles when public Transportation is not practical or available. Examples include travel between hotel and place of business, between airport and hotel, and from one business to another. Fares for travel outside of business hours with no business purpose are considered personal and not reimbursable.

ii. Ride Sharing Company: CalOptima Health does not encourage the use of Ride Sharing Companies, such as Uber or Lyft. However, if no other modes of Transportation are available or economical, CalOptima Health will reimburse Ride Sharing Company fares. Authorized Individuals shall use Ride Sharing Companies at their own risk and discretion, with no liability to CalOptima Health, understanding the dangers of using such services. Customary and reasonable Transportation tips/gratuity may be reimbursed in accordance with Section II.F. Tips and Gratuities.

g. Costs associated with any personal travel made in conjunction with a business travel itinerary will be at the Authorized Individual's expense. Authorized Individuals are expected to be honest in reporting any personal travel plans made in conjunction with business travel, and the Authorized Individual shall document the incremental travel costs assessed to CalOptima Health in accordance with this policy.

2. Lodging

a. CalOptima Health shall reimburse the cost of a single occupancy room at an Approved Lodging Facility for Non-local Travel.

For 20250807 BOD Review Only

Back to Agenda Back to Item

b. Reasonable lodging expenses will be allowed. Price is a factor when selecting lodging, and prudence and good stewardship should be used when selecting a lodging facility. Comparison shopping is encouraged~~,~~ and booking in advance with the conference coordinator or through online travel websites, as opposed to directly with the lodging facility, may provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

   i. Tips and gratuities associated with lodging are at the discretion of the Authorized Individual and will not be reimbursed by CalOptima Health. Please see section II.F Tips and Gratuities.

c. 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: https://www.gsa.gov/travel.

   ~~i. Lodging rates in excess of either the GSA federal lodging per diem rates or the government rate are allowable if the lodging is in conjunction with approved CalOptima Health business.~~

   i. CalOptima Health will reimburse up to 125% of the GSA rate. If the nightly rates differ, the average nightly rate for the stay's duration should be calculated to determine if it is within the 125% threshold. Evidence of the applicable GSA rate must be attached to the employee's expense report.

   ii. Lodging rates in excess of the 125% Federal GSA rate may be reimbursed with prior authorization from the CEO or CFO or if a conference provides a documented lodging discount as part of a group or advance booking, and this rate exceeds the 125% threshold. Evidence of the discount must be attached to the employee's expense report.

d. CalOptima Health may maintain preferred rates with select hotels in the local area. Vendors and consultants conducting CalOptima Health Business who are required to stay overnight and are authorized to receive reimbursement for lodging expenses pursuant to a contract with CalOptima Health, should utilize these preferred hotels, if available. Authorized Individuals should contact a member of the Procurement & Vendor Management Department for information and a link to the reservations department of these preferred hotels.

e. CalOptima Health may reimburse additional nights of lodging expenses for Non-local Travel if~~:~~ (with support):

   i. It results in offsetting lower airfare; and

   ii. The cost of returning ~~to~~ home or to the office at the conclusion of business exceeds the cost of lodging, rental automobile and meals for the additional stay.

f. Local Travel may qualify for an overnight stay, depending on time constraints. CalOptima Health may approve Local Travel lodging expenses if:

   i. It is not practical or feasible for the Authorized Individual to return home due to extremely poor weather conditions; or

For 20250807 BOD Review Only

Back to Agenda Back to Item

ii. Less than eight (8) hours will elapse from the time business is concluded on one (1) day to the time business is scheduled to reconvene on the following calendar day.

g. Once approved, the Authorized Individual or their Designee shall be responsible for making his or her own travel and lodging arrangements, utilizing the CalOptima Health travel services provider or another method approved by the Budget & Vendor Management Department.

h. The Authorized Individual shall be responsible for necessary cancellation of travel and lodging reservations in accordance with the respective rules and time limits. CalOptima Health shall not reimburse Authorized 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 Authorized Individual. The Authorized Individual shall inform the Procurement & Vendor Management Department of any cancellations.

3. Travel Meals

a. Travel Meals are those food items consumed when traveling on CalOptima Health Business overnight and away from the primary workplace.

b. CalOptima Health may reimburse Authorized Individuals the actual cost of Travel Meals, including taxes and gratuity (up to a maximum of 20% of the Authorized Individual's meal) and excluding alcoholic beverages, in an amount not to exceed ~~eighty~~ ninety-two dollars ($~~80~~92.00) per day.

i. When traveling in groups, Authorized Individuals shall pay for his or her own meal when possible. Exceptions approved by Executive Staff will require a notated split of the bill receipt, with each CalOptima Health staff submitting separate Expense Reports for their portion.

c. Under certain conditions, CalOptima Health may reimburse employees and Board or Committee members for Travel Meals that exceed the ninety-two ~~eighty~~ dollars ($~~80~~92.00) per day limit. The employee or Board or Committee member shall submit a valid receipt for such Travel Meals along with a brief explanation of the expenditure which must meet the following conditions:

i. 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.

ii. Expense Reports containing extraordinary meal expenditures shall require approval of the Chief Executive Officer (CEO), or their Designee.

d. CalOptima Health may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board or Committee member Travel Meal reimbursement rate.

e. For Local Travel reimbursement, see Section II.E.1. of this policy.

4. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

For 20250807 BOD Review Only

a. Attendance shall be:

i. Limited to the minimum number of individuals necessary to carry out the business purpose as deemed appropriate by the designated approver as specified in this policy;

ii. For only those whose job tasks or responsibilities are directly related to the purpose of the travel; and

iii. Approved by the department head, Budget staff and Human Resources.

b. Payment of Fees

i. Fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of fees by CalOptima Health at the time the TTA form is prepared and will submit necessary registration information to the Procurement & Vendor Management Department.

ii. In the event an individual must personally pay for Registration Fees, the individual shall request reimbursement on an Expense Report with a pre-approved TTA form.

5. Miscellaneous expenses, including:

a. Insurance for rental vehicles;

b. Parking, Fees and Tolls (i.e., charges for toll roads and necessary parking);

c. Authorized local and long-distance telephone calls;

d. Baggage fees (tips are not reimbursable);

e. Internet or Wi-Fi charges for business-related communication;

f. Facsimiles;

g. Expenses in connection with the preparation of authorized company reports or correspondence; and

h. Other unforeseen or unusual business-related expenses that are properly justified and substantiated.

6. The type of expenses or occurrences that do not qualify for travel reimbursement of expenses include, but are not limited to:

a. Attendance at social, civic, or charitable meetings or functions, which the person would attend regardless of his or her position;

b. Any expenditure or contributions related to political campaigning or charitable fundraisers or events;

c. Expenses for anyone other than the Authorized CalOptima Health Individual attending or participating in the activity or function;

For 20250807 BOD Review Only

Back to Agenda Back to Item

d. The personal portion of any travel;

e. Entertainment expenses, including movies, sporting events, or concerts; or

f. Personal losses incurred while on CalOptima Health business.

D. Cash advances

1. Under normal circumstances, CalOptima Health shall not issue cash advances for travel expenses.

2. CalOptima Health may authorize cash advances on a limited basis if the traveling Authorized Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized travel expenses.

3. A member of the Executive Staff shall approve requests for cash advances for anticipated authorized travel.

4. When authorized, cash advances shall be based on an estimate of reasonable travel expenses, including Transportation, Business Meals, lodging and miscellaneous expenses, and shall have a limit of $1,000 unless approved in advance by the Chief Financial Officer (CFO).

5. Cash advances shall not be provided earlier than thirty (30) days prior to the scheduled travel date(s). Authorized Individuals receiving cash advances shall complete an Expense Report within sixty (60) days of when the Authorized Individual's expenses were paid or incurred, whichever occurs first. The Authorized Individual shall account for all expenses incurred while traveling on authorized CalOptima Health Business and shall indicate and remit any cash amounts due back to CalOptima Health within one hundred and twenty (120) days of when the expenses were paid or incurred in the event the cash advance was greater than actual authorized expenses. In the event the actual authorized expenses exceed the amount of the cash advance, cash amounts due the Authorized Individual will be processed in the next pay period. Failure to return unexpended cash advances or to account for all expenses incurred while traveling may result in corrective action, up to and including termination.

E. Trainings, Meeting, Local Conferences, or Regulatory Audits Meals:

1. CalOptima Health recommends Authorized Individuals conduct internal staff meetings, trainings, and regulatory audits during non-lunch hours. Based on the below criteria, CalOptima Health may reimburse or pay the reasonable cost of ~~meals~~one meal per participant for required meetings, trainings, local conferences or regulatory audits in an amount not to exceed twenty-five dollars ($25.00) per participant meal which includes the cost of delivery, gratuity, and service fees.

a. Expenditure and/or reimbursement with CalOptima Health funds shall be permitted for mandatory staff meetings, trainings, or regulatory audits, if such expenditures meet all ~~of~~ the following three (3) criteria:

~~i.~~ A required or mandatory, in-person, meeting, training, local conference, regulatory audit, or business activity (does not include team building events or off-site social venues) that ~~last~~lasts for a minimum of four (4) hours~~;~~

i. , excluding a~~). An~~ non-working lunch;

For 20250807 BOD Review Only

a) Supporting documentation shall include an agenda detailing the purpose and schedule of the meeting shall be provided with the request for reimbursement.

ii. Supporting documentation ~~for~~shall include the advance written approval of an Executive Director and or Chief, prior to the meeting, training, regulatory audit, or other business activity; and

iii. Supporting documents ~~for the Expense Report or check request, including~~shall include the meeting or training agenda and ~~list~~the listing of CalOptima Health participants~~.~~ that supports the $25.00 limit.

2. Under no circumstances or conditions will meals be permitted or reimbursed for social functions or events, including, but not limited to the following:

a. Holiday parties (with the exception of an organization-wide mandatory event);

b. Birthdays;

c. Baby showers;

d. Marriage celebrations;

e. Retirements;

f. Department-only employee appreciation or celebration;

g. Other personal employee celebrations;

h. Expenditures for alcoholic beverages, including related tax and tip;

i. Voluntary events or functions, including, but not limited to, employee lunch time and/or after work group outings, team building events, and/or other off-site social functions (with the exception of training and self-development programs established and/or approved by the Human Resources Department); or

j. Provider gifts.

F. Business Activity Meals

1. CalOptima Health may provide reimbursement to CalOptima Health Employees for budgeted Business Meals with written approval from the CEO or CFO. The ~~per participant~~ meal limit is twenty-five dollars ($25) which includes the cost of delivery, gratuity, and services fees. CalOptima shall not reimburse the cost of meals for individuals not employed by CalOptima Health. ~~Business~~If there are other CalOptima employees at the business lunch, they must request separate receipts for their submission of an expense report. –The business purpose must be indicated on the Expense Report.

G. Tips and Gratuities: CalOptima Health will provide reimbursement to the Authorized Individual for Tips and Gratuities up to twenty (20) percent of the total charge for allowable expenditures as long as the supporting receipt can be validated.

For 20250807 BOD Review Only

Back to Agenda Back to Item

1. Tips and Gratuities for allowable expenditures include meals, ride-sharing, and food delivery. Supporting documentation of the total cost including tips and gratuities must be included for reimbursement requests.

2. CalOptima Health shall not reimburse Tips and Gratuities without a receipt and those paid in cash without acceptable documentation as proof of payment.

3. CalOptima Health shall not reimburse Tips and Gratuities related to, but not limited to, the following:

   a. Lodging-related services, such as housekeeping, valet, and bell desk; or

   b. Expenditures that are otherwise not reimbursable under this policy.

H. Public Activities and Community Events: CalOptima Health will reimburse budgeted expenses for public activities and community events that are held for CalOptima Health members and providers.

1. Authorized Individuals shall confirm sufficient budgeted funds are available for expenditures for the public activities or community events.

2. Authorized Individual shall submit a purchase requisition in advance of the public activity or community event for projected expenditures.

   a. In circumstances where a purchase requisition is not possible, Authorized Individual shall obtain approval from the CEO or their Designee in accordance with the Policy AA.1223: Participation in Community Events by External Entities

3. When catering meals, CalOptima Health recommends Authorized Individuals utilize one of CalOptima Health's contracted companies. Authorized Individuals shall contact a member of the Procurement & Vendor Management Department for information.

4. Authorized Individuals shall include supporting documents of the event such as the agenda/event flyer when submitting an Expense Report.

I. Business-related Professional Licenses and Membership Dues: CalOptima Health may reimburse budgeted business-related professional licenses and membership dues that are required under CalOptima Health Policy GA.8033: License and Certification Tracking or are necessary for an Authorized Individual's job duties. ~~It is suggested to contact the Procurement & Vendor Management Department for information on the payment through the requisition process.~~

J. CalOptima Health will not provide reimbursement for gift cards purchased for internal training, staff recognition events, department events, and/or social functions.

III. PROCEDURE

A. Travel and Training Authorization (TTA) Form

1. All travel requests and requests for anticipated reimbursement of related expenses must be submitted online by Authorized Individuals or their Designee using CalOptima Health's Intranet system (or similar system in place at the time the request is made), and shall include all actual or estimated expense amounts related to the request; and

For 20250807 BOD Review Only

Back to Agenda Back to Item

2. Such requests shall be routed for approval based on the Authorized Individual's level, cost center, and whether the Authorized Individual is a CalOptima Health Employee according to the following:

   a. Individual Departments are responsible for including anticipated travel expenses in the Department's operating budget.

   b. Budgeted Expenses: All budgeted travel and miscellaneous expenses for Authorized Individuals must be approved by the appropriate level of CalOptima Health Senior Management, prior to travel expenses being incurred, according to the following:

Individual	**Approver**
Employee through Department Manager	Department Director
Department Director	Executive Staff
Executive Director	Departmental Chief or Designee
Departmental Chief Officers	CEO or Designee
Chief Executive Officer	CFO or Designee
Board Member/Standing Committee Member	CEO or Designee

   c. If expenses exceed the originally approved TTA, then a supplemental TTA is required to be attached as proof of budget availability.

   d. Non-Budgeted Expenses: Non-budgeted travel and miscellaneous expenses for Authorized Individuals may be approved if the expenditures are appropriated and authorized in accordance with CalOptima Health Policy GA.5003: Budget and Operations Forecasting, prior to travel expenses being incurred.

3. All requests shall be routed to the Human Resources Department ~~in order~~ to ~~track~~provide for tracking of the Authorized Individual's training.

4. The Procurement & Vendor Management Department shall review all requests to verify that requested expenses are budgeted, and that sufficient budgeted funds are available to cover the requested expenses.

5. The Authorized Individual or Designee 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 Procurement & Vendor Management Department shall review, authorize for appropriate approvals, and notify the Authorized Individual or Designee that they may begin making travel arrangements if not already completed by the Budget & Vendor Management Department.

B. Travel and Training Arrangements

1. Authorizations that include event Registration Fees shall be pre-paid and processed by the Budget & Vendor Management Department, when possible. The Procurement & Vendor Management Department shall verify with the Authorized Individual or Designee that the registration has not been processed before proceeding with registration for the event.

2. The Authorized Individual or Designee shall make air travel arrangements through CalOptima Health's travel services provider which is done through CalOptima Health's administrative assistants. Arrangements should be made as far in advance as possible to minimize costs.

For 20250807 BOD Review Only

Exceptions to using CalOptima Health's travel services provider are subject to approval by the Procurement & Vendor Management Department and will be reimbursed using an Expense Report. Employees granted the exception to book their own airfare shall not use personal credit card points, as CalOptima Health does not reimburse for this method of booking.

3. All other arrangements shall be made with the Authorized Individual's personal credit card.

C. Expense Reimbursement using an Expense Report

1. Authorized Individuals or Designees shall prepare and submit claims for reimbursement of travel and other Reimbursable Expenses through the online CalOptima Health Expense Report system with an access link available on CalOptima Health's InfoNet. or incurred, whichever occurs first. Once the Expense Report has been completed, the Authorized Individual shall review and submit the Expense Report within the system. The system allows for the electronic selection of an applicable TTA form, and electronically routes the Expense Report for management approvals according to the Authorized Individual's home department based on the threshold amounts and corresponding management approval levels in the table below.

Threshold Up Through	**Approver**
$1,000	Manager and Senior Manager
Over $1,000	Director

Note: Designee authorization is not valid when self-approval would result.

2. Receipts

a. For each expense, the Authorized Individual or Designee shall include an original itemized receipt, if available, or other computer-generated or hand-written receipt, in the event the original receipt is unavailable. The receipt shall include line item details of all eligible charges being submitted for reimbursement. If an itemized food receipt is not available, then a worksheet providing the line items ordered, cost and name of restaurant is acceptable to accompany receipts in a summarized format.

b. In the event an original receipt is unavailable, CalOptima Health may accept alternative documentation for proof of purchase and/or payment, such as computer-generated receipts, hand-written receipts, and/or excerpt of credit card statement with a detailed description of the charges.

c. Small sized receipts, such as credit card, gas and airline receipts, shall be attached to an 8.5 by 11-inch sheet of paper and attached as a document image.

d. Hotel receipts and other larger size receipts may be submitted in their original form.

i. Hotel receipts that have charges for food or non-alcoholic beverages should be notated in the meal category section on the Expense Report and removed from the lodging total. CalOptima Health shall reimburse room service charges and tips for food or beverage for a combined total up to twenty percent (20%).

ii. In-room movies are considered personal and not reimbursable.

e. In most instances, airfare for CalOptima Health Employees and Board members shall be prepaid by CalOptima Health. CalOptima Health contractors authorized to receive reimbursement for airfare, and employees and Board members for whom airfare was not

For 20250807 BOD Review only

prepaid for any reason, shall submit invoices for passenger receipts for reimbursement consideration through Accounts Payable.

f. 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 Health shall not reimburse the expense.

3. Completed and approved Expense Reports with supporting documentation shall be submitted to the Accounting Department in a timely manner, preferably within thirty (30) days of completion of travel, but in no event beyond sixty (60) days after the expense is paid or incurred. Expense Reports are paid with the next payroll processing cycle and included on the employee's payroll check.

4. No reimbursement shall be made for Expense Reports submitted beyond sixty (60) days after completion of travel or when the expenses were paid or incurred, whichever occurs first.

a. Authorized Individuals may request an exception to the submission deadline, which is subject to the review and approval by the Controller.

D. The Accounting Department shall:

1. Review submitted Expense Reports and supporting documentation for completeness;

a. During the review, Accounting shall contact the Authorized Individual to request any missing supporting documentation.

b. Accounting shall provide advance communication of any denied reimbursement claims.

c. An Authorized Individual may dispute denied reimbursement claims by providing a narrative and/or additional supporting documentation to be reviewed by the Controller.

2. Review expense codes for appropriate department and general ledger account numbers; and

3. Process payment for reimbursement as a non-taxable miscellaneous reimbursement.

E. The Procurement & Vendor Management Department shall:

1. Provide travel reports to the CEO, Executive Staff and department directors, upon request. Such reports may include a summary of travel by department, purpose, cost, and number of Authorized Individuals per event;

2. Review details of statements/invoices received from the CalOptima Health travel services provider for accuracy ~~and reasonableness~~;

3. ~~Attach appropriate copies~~Maintain a database of completed TTA forms related to travel service provider invoice line items and shall submit ~~them~~supported monthly invoices to Accounts Payable for payment;

4. Review details of statements/invoices received from the credit card account ~~used by the Procurement & Vendor Management Department~~ to arrange attendance at conferences, trainings, and other events, and ~~to make~~for making authorized purchases; and

For 20250807 BOD Review Only

5. ~~Attach appropriate copies~~Maintain a database of ~~completed TTA forms related to~~approved credit card invoice travel and training line items and once reviewed, submit ~~them~~the supported invoices to Accounts Payable for payment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Bylaws of Orange County Health Authority dba Orange Prevention and Treatment Integrated Medical Assistance, Adopted December 6, 1994
B. CalOptima Health Policy GA.5003: Budget and Operations Forecasting
C. CalOptima Health Policy GA.8033: License and Certification Tracking
D. CalOptima Health Policy GA.8042: Supplemental Compensation
E. CalOptima Health Policy GA.1223: Participation in Community Events by External Entities
F. Internal Revenue Service Publication 463
G. California Government Code Section 53232.2
H. California Labor Code Section 2802
I. Title 26, Code of Federal Regulations §§ 1.62-2

VI. REGULATORY AGENCY APPROVAL(S)

Not Applicable

VII. BOARD ACTION(S)

Date	Meeting
09/06/2012	Regular Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors
11/02/2023	Regular Meeting of the CalOptima Health Board of Directors
08/07/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2012	GA.5004	Travel Policy	Administrative
Revised	09/06/2012	GA.5004	Travel Policy	Administrative
Revised	03/01/2013	GA.5004	Travel Policy	Administrative
Revised	03/03/2022	GA.5004	Travel Policy	Administrative
Revised	12/01/2022	GA.5004	Travel and Business Meal Policy	Administrative
Revised	11/02/2023	GA.5004	Travel and Other Reimbursable Expenses	Administrative
Revised	10/01/2024	GA.5004	Travel and Other Reimbursable Expenses	Administrative
Revised	07/01/2025	GA.5004	Travel and Other Reimbursable Expenses	Administrative

For BOD Review Only

Back to Agenda Back to Item

IX. GLOSSARY

Term	Definition
Authorized Individual	Persons authorized to submit an Expense Report for reimbursement of travel, meal, lodging, or other allowable expenses, including: CalOptima Health Board members, CalOptima Health Standing Committee Members, CalOptima Health Employees, and individuals under contract to CalOptima Health for which the approved contract provides for reimbursement of travel and/or conference expenses.
Approved Lodging Facility	Any overnight sleeping facilities which offer a discounted government rate to authorized individuals traveling on behalf of CalOptima Health.
Business Meals	Breakfast, lunch, dinner, snacks, refreshments, and related tips and taxes where business is discussed between authorized CalOptima staff and industry peers or business associates over the course of a meal.
CalOptima Health Business	Activities or functions which a department head determines are directly related to or in support of the ordinary, necessary and/or required mission and business functions of CalOptima Health.
CalOptima Health Employees	Includes, but are not limited to, all full-time and part-time regular CalOptima Health employees, all temporary employees, interns, CalOptima Health Board members, and applicable contractors and consultants.
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.
Executive Staff	Staff holding Executive level positions as designated by the Board of Directors.
Expense Report	Detailed and itemized report that tracks expenses incurred during the course of performing necessary job functions.
Governing Body	The Board of Directors of CalOptima Health.
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Health Board of Directors who provide advice and recommendations regarding the organization's investments.
Local Travel	Travel to a destination that is 50 miles or less away from the primary workplace or home and does not generally include an overnight stay.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Non-local Travel	Travel which is more than 50 miles away from the primary workplace or home and may require an overnight stay.
Non-Reimbursable Expenses	Expenses that are not a necessary part of or approved as part of the required travel. Commuting between a traveler's home and regularly assigned work location is not considered official business.
Parking, Fees and Tolls	Charges for ferries, bridges, tunnels, toll roads, and necessary parking.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima Health to advise its Board of Directors on issues impacting the CalOptima Health Provider community.

For 20250907 BOD Review Only

Back to Agenda Back to Item

Term	Definition
Registration Fees	Actual fees paid for registration to attend authorized conferences, seminars, conventions, trainings or meetings of professional societies or community organizations.
Reimbursable Expenses	Reimbursable expenses include but are not limited to the cost of travel, transportation, catering and meals, lodging, business-related professional licenses and membership dues, public activities, and other actual and necessary business -related expenses incurred by CalOptima Health Employees, Governing Body, Standing Committee Members, and authorized contractors and consultants while conducting authorized CalOptima Health Business.
Standing Committee Members	Non-Board and non-employee members of the CalOptima Health Investment Advisory Committee (IAC), Provider Advisory Committee (PAC), Member Advisory Committee (MAC), OneCare Connect MAC, and Whole Child Model Family Advisory Committee.
Transportation	Bus, rail or airfare, car rental, taxi, ride sharing, shuttle, parking fees, tolls, and mileage for use of personal vehicle.
Travel Meals	Travel Meals are those food items consumed when traveling on CalOptima Health business that is considered Non-local Travel.

For 20250807 BOD Review Only

Policy:	GA.5004
Title:	**Travel and Other Reimbursable Expenses**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/2012
Revised Date:	07/01/2025
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250807 BOD Review Only

I. PURPOSE

This policy establishes a uniform standard and process for reasonable and equitable reimbursement of approved travel, Transportation, catering and meals, lodging, business-related professional licenses and membership dues, public activities, and other actual and necessary business-related expenses incurred by CalOptima Health Employees, Governing Body, Standing Committee Members, and authorized contractors and consultants while conducting authorized CalOptima Health Business.

II. POLICY

A. CalOptima Health shall comply with all applicable laws and regulations to provide and reimburse Authorized Individuals for business-related expenses, which includes travel, Transportation, catering and meals, lodging, business-related professional licenses and membership dues, public activities, and other actual and necessary business-related expenses. The Finance Department shall implement an approval and reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel, Transportation, meals, lodging, and miscellaneous expenses incurred by Authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal laws and regulations.

B. CalOptima Health shall reimburse Authorized Individuals for reasonable, actual, and necessary expenses incurred while conducting CalOptima Health Business. Reimbursements for CalOptima Health business-related expenses shall be made in accordance with the Internal Revenue Service's (IRS) requirements, particularly the rules for an accountable plan, which requires: (1) expenses to have a business connection; (2) expenses be adequately accounted for within a reasonable period of time; and (3) any excess reimbursement or allowance be returned within a reasonable period of time. Reimbursement may be authorized when there is a clear connection or nexus between the attendance of the individual at such activity or function and the performance of official duties for which such an individual is regularly employed.

C. Business-related expenses for travel while conducting CalOptima Health Business 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, avoiding peak travel times, and leveraging efficiency by combining multiple meetings

Back to Agenda Back to Item

and events whenever possible. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible. Reimbursable travel expenses include actual and necessary expenses, such as:

1. Transportation: Including, but not limited to, commercial carriers, rental vehicles, mileage for use of personal vehicles, taxis, recognized ride-share companies, shuttles, and public transit fares.

    a. In selecting the mode of Transportation**,** the Authorized Individual shall consider 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.

    b. The Authorized 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.

        i. Authorized Individuals may, for personal convenience, travel to their final destination on an indirect route, or on an interrupted direct route, if approved in advance within the Travel and Training Authorization (TTA) form. An Authorized 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.

        ii. Additional expenses shall not be the responsibility of the Authorized Individual if, through no fault or control of the Authorized 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.

        iii. Whenever available, all Authorized 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, unless First or Business Class is shown to be cheaper than coach (proof of price is required for reimbursement).

        iv. Authorized 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.

        v. Any deviation from the lowest available rate for commercial carriers shall be at the Authorized Individual's expense.

    c. The Authorized Individual shall be responsible for necessary cancellation of travel reservations, in accordance with the respective carriers' rules and time limits. CalOptima Health shall not reimburse Authorized Individuals for fees associated with the failure to cancel reservations within the established carrier's rules and time limits unless the failure was due to circumstances beyond the control of the Authorized Individual. The Authorized Individual must also inform the Procurement & Vendor Management Department of any such cancellations.

    d. Use of Privately-Owned Vehicles

For 20250807 POD Review Only

Back to Agenda Back to Item

i. 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 Authorized Individual must be licensed and shall carry liability insurance as required by the State of California, at the Authorized Individual's sole expense.

ii. CalOptima Health shall reimburse the use of privately-owned vehicles solely based on actual mileage at the IRS Standard Mileage Rate at the time of travel. The Authorized Individual shall report total mileage reduced by the round-trip mileage distance between their residence and their CalOptima Health central worksite, except in the following situations:

a) If a teleworker is classified as a Community Worker by Human Resources, CalOptima Health shall reimburse for the round-trip mileage from the teleworker's remote work location to the off-site location.

b) If an Authorized Individual's scheduled workday begins and ends at the CalOptima Health central worksite, any required off-site travel during the day shall be reimbursed for the round-trip mileage from CalOptima Health's central worksite to the off-site location and back; or.

c) If an Authorized Individual is required to travel for a CalOptima Health function that occurs on a day where the Authorized Individual is not normally scheduled to work, CalOptima Health shall reimburse the round-trip mileage from the Authorized Individual's home to the CalOptima Health function's location.

iii. For Authorized Individuals who receive an automobile allowance pursuant to CalOptima Health Policy GA.8042: Supplemental Compensation, CalOptima Health will only reimburse actual mileage at the IRS Standard Mileage Rate for travel that exceeds a round-trip of 100 miles based on the distance of the final destination from the individual's primary worksite. Use of privately-owned vehicles within a round-trip of 100 miles or less per meeting or event based on the distance of the final destination from the individual's primary workplace is covered as part of the automobile allowance.

iv. CalOptima Health shall not reimburse costs for fuel, automobile repairs, other automobile expense items, or traffic/parking citations.

v. If more than one Authorized Individual is traveling for CalOptima Health Business in the same personal vehicle, only one person shall be reimbursed for the use of a privately-owned vehicle.

vi. Travel shall be by the most practical direct route. Any person traveling by an indirect route shall assume any additional expense incurred.

vii. CalOptima Health shall compensate property damages to an Authorized Individual's automobile incurred without fault or cause on the part of the Authorized Individual up to two hundred fifty dollars ($250), or the amount of the deductible on the person's insurance policy, whichever is the lesser amount, for each accident.

e. Rental Automobiles

For 20250807 BOD Review Only

Back to Agenda Back to Item

i. An Authorized Individual may rent an automobile when such rental is considered to be more advantageous to CalOptima Health than other means of Transportation.

ii. Advance reservations shall be made whenever possible. Reservations for the Authorized Individual and the vehicle rental agreement shall be made in the person's name, acting for CalOptima Health. i.e., John Doe, for CalOptima Health.

iii. Rental automobile approved classes are as follows:

a) Economy Class or equivalent: An Authorized Individual shall select an economy class vehicle whenever four (4) or fewer Authorized Individuals, including the driver, will be passengers in the rental automobile at any one time.

b) Mid-size Class or equivalent: An Authorized Individual may select a mid-size class vehicle in the event more than four (4) Authorized 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 or if the cost is lower than that of an economy class (Documented support required).

c) Luxury Class or equivalent: Under no circumstances shall an individual select a luxury class vehicle.

f. Other Modes of Transportation

i. Taxi Fares or Shuttles: CalOptima Health shall reimburse taxi fares or shuttles when public Transportation is not practical or available. Examples include travel between hotel and place of business, between airport and hotel, and from one business to another. Fares for travel outside of business hours with no business purpose are considered personal and not reimbursable.

ii. Ride Sharing Company: CalOptima Health does not encourage the use of Ride Sharing Companies, such as Uber or Lyft. However, if no other modes of Transportation are available or economical, CalOptima Health will reimburse Ride Sharing Company fares. Authorized Individuals shall use Ride Sharing Companies at their own risk and discretion, with no liability to CalOptima Health, understanding the dangers of using such services. Customary and reasonable Transportation tips/gratuity may be reimbursed in accordance with Section II.F. Tips and Gratuities.

g. Costs associated with any personal travel made in conjunction with a business travel itinerary will be at the Authorized Individual's expense. Authorized Individuals are expected to be honest in reporting any personal travel plans made in conjunction with business travel, and the Authorized Individual shall document the incremental travel costs assessed to CalOptima Health in accordance with this policy.

2. Lodging

a. CalOptima Health shall reimburse the cost of a single occupancy room at an Approved Lodging Facility for Non-local Travel.

b. Reasonable lodging expenses will be allowed. Price is a factor when selecting lodging, and prudence and good stewardship should be used when selecting a lodging facility. Comparison shopping is encouraged and booking in advance with the conference coordinator or through online travel websites, as opposed to directly with the lodging

For 20250807 BOD Review Only

Back to Agenda Back to Item

facility, may provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

i. Tips and gratuities associated with lodging are at the discretion of the Authorized Individual and will not be reimbursed by CalOptima Health. Please see section II.F Tips and Gratuities.

c. Travelers should seek lodging rates (excluding taxes and fees) at or below the federal government's per diem rate. A schedule of federal lodging per diem rates is available on the U.S. General Services Administration (GSA) website: https://www.gsa.gov/travel.

i. CalOptima Health will reimburse up to 125% of the GSA rate. If the nightly rates differ, the average nightly rate for the stay's duration should be calculated to determine if it is within the 125% threshold. Evidence of the applicable GSA rate must be attached to the employee's expense report.

ii. Lodging rates in excess of the 125% Federal GSA rate may be reimbursed with prior authorization from the CEO or CFO or if a conference provides a documented lodging discount as part of a group or advance booking, and this rate exceeds the 125% threshold. Evidence of the discount must be attached to the employee's expense report.

d. CalOptima Health may maintain preferred rates with select hotels in the local area. Vendors and consultants conducting CalOptima Health Business who are required to stay overnight and are authorized to receive reimbursement for lodging expenses pursuant to a contract with CalOptima Health, should utilize these preferred hotels, if available. Authorized Individuals should contact a member of the Procurement & Vendor Management Department for information and a link to the reservations department of these preferred hotels.

e. CalOptima Health may reimburse additional nights of lodging expenses for Non-local Travel if (with support):

i. It results in offsetting lower airfare; and

ii. The cost of returning home or to the office at the conclusion of business exceeds the cost of lodging, rental automobile and meals for the additional stay.

f. Local Travel may qualify for an overnight stay, depending on time constraints. CalOptima Health may approve Local Travel lodging expenses if:

i. It is not practical or feasible for the Authorized Individual to return home due to extremely poor weather conditions; or

ii. Less than eight (8) hours will elapse from the time business is concluded on one (1) day to the time business is scheduled to reconvene on the following calendar day.

g. Once approved, the Authorized Individual or their Designee shall be responsible for making his or her own travel and lodging arrangements, utilizing the CalOptima Health travel services provider or another method approved by the Budget & Vendor Management Department.

h. The Authorized Individual shall be responsible for necessary cancellation of travel and lodging reservations in accordance with the respective rules and time limits. CalOptima

For 20250807 BOD Review Only

Back to Agenda Back to Item

Health shall not reimburse Authorized 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 Authorized Individual. The Authorized Individual shall inform the Procurement & Vendor Management Department of any cancellations.

3. Travel Meals

   a. Travel Meals are those food items consumed when traveling on CalOptima Health Business overnight and away from the primary workplace.

   b. CalOptima Health may reimburse Authorized Individuals the actual cost of Travel Meals, including taxes and gratuity (up to a maximum of 20% of the Authorized Individual's meal) and excluding alcoholic beverages, in an amount not to exceed ninety-two dollars ($92.00) per day.

      i. When traveling in groups, Authorized Individuals shall pay for his or her own meal when possible. Exceptions approved by Executive Staff will require a notated split of the bill receipt, with each CalOptima Health staff submitting separate Expense Reports for their portion.

   c. Under certain conditions, CalOptima Health may reimburse employees and Board or Committee members for Travel Meals that exceed the ninety-two dollars ($92.00) per day limit. The employee or Board or Committee member shall submit a valid receipt for such Travel Meals along with a brief explanation of the expenditure which must meet the following conditions:

      i. 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.

      ii. Expense Reports containing extraordinary meal expenditures shall require approval of the Chief Executive Officer (CEO), or their Designee.

   d. CalOptima Health may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board or Committee member Travel Meal reimbursement rate.

   e. For Local Travel reimbursement, see Section II.E.1. of this policy.

4. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

   a. Attendance shall be:

      i. Limited to the minimum number of individuals necessary to carry out the business purpose as deemed appropriate by the designated approver as specified in this policy;

      ii. For only those whose job tasks or responsibilities are directly related to the purpose of the travel; and

      iii. Approved by the department head, Budget staff and Human Resources.

For 20250807 BOD Review Only

Back to Agenda Back to Item

b. Payment of Fees

i. Fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of fees by CalOptima Health at the time the TTA form is prepared and will submit necessary registration information to the Procurement & Vendor Management Department.

ii. In the event an individual must personally pay for Registration Fees, the individual shall request reimbursement on an Expense Report with a pre-approved TTA form.

5. Miscellaneous expenses, including:

a. Insurance for rental vehicles;

b. Parking, Fees and Tolls (i.e., charges for toll roads and necessary parking);

c. Authorized local and long-distance telephone calls;

d. Baggage fees (tips are not reimbursable);

e. Internet or Wi-Fi charges for business-related communication;

f. Facsimiles;

g. Expenses in connection with the preparation of authorized company reports or correspondence; and

h. Other unforeseen or unusual business-related expenses that are properly justified and substantiated.

6. The type of expenses or occurrences that do not qualify for travel reimbursement of expenses include, but are not limited to:

a. Attendance at social, civic, or charitable meetings or functions, which the person would attend regardless of his or her position;

b. Any expenditure or contributions related to political campaigning or charitable fundraisers or events;

c. Expenses for anyone other than the Authorized CalOptima Health Individual attending or participating in the activity or function;

d. The personal portion of any travel;

e. Entertainment expenses, including movies, sporting events, or concerts; or

f. Personal losses incurred while on CalOptima Health business.

D. Cash advances

1. Under normal circumstances, CalOptima Health shall not issue cash advances for travel expenses.

For 20250807 BOD Review Only

Back to Agenda Back to Item

2. CalOptima Health may authorize cash advances on a limited basis if the traveling Authorized Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized travel expenses.

3. A member of the Executive Staff shall approve requests for cash advances for anticipated authorized travel.

4. When authorized, cash advances shall be based on an estimate of reasonable travel expenses, including Transportation, Business Meals, lodging and miscellaneous expenses, and shall have a limit of $1,000 unless approved in advance by the Chief Financial Officer (CFO).

5. Cash advances shall not be provided earlier than thirty (30) days prior to the scheduled travel date(s). Authorized Individuals receiving cash advances shall complete an Expense Report within sixty (60) days of when the Authorized Individual's expenses were paid or incurred, whichever occurs first. The Authorized Individual shall account for all expenses incurred while traveling on authorized CalOptima Health Business and shall indicate and remit any cash amounts due back to CalOptima Health within one hundred and twenty (120) days of when the expenses were paid or incurred in the event the cash advance was greater than actual authorized expenses. In the event the actual authorized expenses exceed the amount of the cash advance, cash amounts due the Authorized Individual will be processed in the next pay period. Failure to return unexpended cash advances or to account for all expenses incurred while traveling may result in corrective action, up to and including termination.

E. Trainings, Meeting, Local Conferences, or Regulatory Audits Meals:

1. CalOptima Health recommends Authorized Individuals conduct internal staff meetings, trainings, and regulatory audits during non-lunch hours. Based on the below criteria, CalOptima Health may reimburse or pay the reasonable cost of one meal per participant for required meetings, trainings, local conferences or regulatory audits in an amount not to exceed twenty-five dollars ($25.00) per participant meal which includes the cost of delivery, gratuity, and service fees.

   a. Expenditure and/or reimbursement with CalOptima Health funds shall be permitted for mandatory staff meetings, trainings, or regulatory audits, if such expenditures meet all the following three (3) criteria:

      i. A required or mandatory, in-person, meeting, training, local conference, regulatory audit, or business activity (does not include team building events or off-site social venues) that lasts for a minimum of four (4) hours, excluding a non-working lunch;

         a) Supporting documentation shall include an agenda detailing the purpose and schedule of the meeting shall be provided with the request for reimbursement.

      ii. Supporting documentation shall include the advance written approval of an Executive Director and or Chief, prior to the meeting, training, regulatory audit, or other business activity; and

      iii. Supporting documents shall include the meeting or training agenda and the listing of CalOptima Health participants that supports the $25.00 limit.

2. Under no circumstances or conditions will meals be permitted or reimbursed for social functions or events, including, but not limited to the following:

For 20250807 BOD Review Only

Back to Agenda Back to Item

a. Holiday parties (with the exception of an organization-wide mandatory event);

b. Birthdays;

c. Baby showers;

d. Marriage celebrations;

e. Retirements;

f. Department-only employee appreciation or celebration;

g. Other personal employee celebrations;

h. Expenditures for alcoholic beverages, including related tax and tip;

i. Voluntary events or functions, including, but not limited to, employee lunch time and/or after work group outings, team building events, and/or other off-site social functions (with the exception of training and self-development programs established and/or approved by the Human Resources Department); or

j. Provider gifts.

F. Business Activity Meals

1. CalOptima Health may provide reimbursement to CalOptima Health Employees for budgeted Business Meals with written approval from the CEO or CFO. The meal limit is twenty-five dollars ($25) which includes the cost of delivery, gratuity, and services fees. CalOptima shall not reimburse the cost of meals for individuals not employed by CalOptima Health. If there are other CalOptima employees at the business lunch, they must request separate receipts for their submission of an expense report. The business purpose must be indicated on the Expense Report.

G. Tips and Gratuities: CalOptima Health will provide reimbursement to the Authorized Individual for Tips and Gratuities up to twenty (20) percent of the total charge for allowable expenditures as long as the supporting receipt can be validated.

1. Tips and Gratuities for allowable expenditures include meals, ride-sharing, and food delivery. Supporting documentation of the total cost including tips and gratuities must be included for reimbursement requests.

2. CalOptima Health shall not reimburse Tips and Gratuities without a receipt and those paid in cash without acceptable documentation as proof of payment.

3. CalOptima Health shall not reimburse Tips and Gratuities related to, but not limited to, the following:

a. Lodging-related services, such as housekeeping, valet, and bell desk; or

b. Expenditures that are otherwise not reimbursable under this policy.

For 20250807 BOD Review Only

H. Public Activities and Community Events: CalOptima Health will reimburse budgeted expenses for public activities and community events that are held for CalOptima Health members and providers.

1. Authorized Individuals shall confirm sufficient budgeted funds are available for expenditures for the public activities or community events.

2. Authorized Individual shall submit a purchase requisition in advance of the public activity or community event for projected expenditures.

a. In circumstances where a purchase requisition is not possible, Authorized Individual shall obtain approval from the CEO or their Designee in accordance with the Policy AA.1223: Participation in Community Events by External Entities

3. When catering meals, CalOptima Health recommends Authorized Individuals utilize one of CalOptima Health's contracted companies. Authorized Individuals shall contact a member of the Procurement & Vendor Management Department for information.

4. Authorized Individuals shall include supporting documents of the event such as the agenda/event flyer when submitting an Expense Report.

I. Business-related Professional Licenses and Membership Dues: CalOptima Health may reimburse budgeted business-related professional licenses and membership dues that are required under CalOptima Health Policy GA.8033: License and Certification Tracking or are necessary for an Authorized Individual's job duties.

J. CalOptima Health will not provide reimbursement for gift cards purchased for internal training, staff recognition events, department events, and/or social functions.

III. PROCEDURE

A. Travel and Training Authorization (TTA) Form

1. All travel requests and requests for anticipated reimbursement of related expenses must be submitted online by Authorized Individuals or their Designee using CalOptima Health's Intranet system (or similar system in place at the time the request is made), and shall include all actual or estimated expense amounts related to the request; and

2. Such requests shall be routed for approval based on the Authorized Individual's level, cost center, and whether the Authorized Individual is a CalOptima Health Employee according to the following:

a. Individual Departments are responsible for including anticipated travel expenses in the Department's operating budget.

b. Budgeted Expenses: All budgeted travel and miscellaneous expenses for Authorized Individuals must be approved by the appropriate level of CalOptima Health Senior Management, prior to travel expenses being incurred, according to the following:

Individual	**Approver**
Employee through Department Manager	Department Director
Department Director	Executive Staff
Executive Director	Departmental Chief or Designee

For 20250807 BOD Review Only

Back to Agenda Back to Item

Departmental Chief Officers	CEO or Designee
Chief Executive Officer	CFO or Designee
Board Member/Standing Committee Member	CEO or Designee

c. If expenses exceed the originally approved TTA, then a supplemental TTA is required to be attached as proof of budget availability.

d. Non-Budgeted Expenses: Non-budgeted travel and miscellaneous expenses for Authorized Individuals may be approved if the expenditures are appropriated and authorized in accordance with CalOptima Health Policy GA.5003: Budget and Operations Forecasting, prior to travel expenses being incurred.

3. All requests shall be routed to the Human Resources Department to provide for tracking of the Authorized Individual's training.

4. The Procurement & Vendor Management Department shall review all requests to verify that requested expenses are budgeted, and that sufficient budgeted funds are available to cover the requested expenses.

5. The Authorized Individual or Designee 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 Procurement & Vendor Management Department shall review, authorize for appropriate approvals, and notify the Authorized Individual or Designee that they may begin making travel arrangements if not already completed by the Budget & Vendor Management Department.

B. Travel and Training Arrangements

1. Authorizations that include event Registration Fees shall be pre-paid and processed by the Budget & Vendor Management Department, when possible. The Procurement & Vendor Management Department shall verify with the Authorized Individual or Designee that the registration has not been processed before proceeding with registration for the event.

2. The Authorized Individual or Designee shall make air travel arrangements through CalOptima Health's travel services provider which is done through CalOptima Health's administrative assistants. Arrangements should be made as far in advance as possible to minimize costs. Exceptions to using CalOptima Health's travel services provider are subject to approval by the Procurement & Vendor Management Department and will be reimbursed using an Expense Report. Employees granted the exception to book their own airfare shall not use personal credit card points, as CalOptima Health does not reimburse for this method of booking.

3. All other arrangements shall be made with the Authorized Individual's personal credit card.

C. Expense Reimbursement using an Expense Report

1. Authorized Individuals or Designees shall prepare and submit claims for reimbursement of travel and other Reimbursable Expenses through the online CalOptima Health Expense Report system with an access link available on CalOptima Health's InfoNet. or incurred, whichever occurs first. Once the Expense Report has been completed, the Authorized Individual shall review and submit the Expense Report within the system. The system allows for the electronic selection of an applicable TTA form, and electronically routes the Expense Report for

For 20250807 BOD Review Only

Back to Agenda Back to Item

management approvals according to the Authorized Individual's home department based on the threshold amounts and corresponding management approval levels in the table below.

Threshold Up Through	Approver
$1,000	Manager and Senior Manager
Over $1,000	Director

Note: Designee authorization is not valid when self-approval would result.

2. Receipts

   a. For each expense, the Authorized Individual or Designee shall include an original itemized receipt, if available, or other computer-generated or hand-written receipt, in the event the original receipt is unavailable. The receipt shall include line item details of all eligible charges being submitted for reimbursement. If an itemized food receipt is not available, then a worksheet providing the line items ordered, cost and name of restaurant is acceptable to accompany receipts in a summarized format.

   b. In the event an original receipt is unavailable, CalOptima Health may accept alternative documentation for proof of purchase and/or payment, such as computer-generated receipts, hand-written receipts, and/or excerpt of credit card statement with a detailed description of the charges.

   c. Small sized receipts, such as credit card, gas and airline receipts, shall be attached to an 8.5 by 11-inch sheet of paper and attached as a document image.

   d. Hotel receipts and other larger size receipts may be submitted in their original form.

      i. Hotel receipts that have charges for food or non-alcoholic beverages should be notated in the meal category section on the Expense Report and removed from the lodging total. CalOptima Health shall reimburse room service charges and tips for food or beverage for a combined total up to twenty percent (20%).

      ii. In-room movies are considered personal and not reimbursable.

   e. In most instances, airfare for CalOptima Health Employees and Board members shall be prepaid by CalOptima Health. CalOptima Health contractors authorized to receive reimbursement for airfare, and employees and Board members for whom airfare was not prepaid for any reason, shall submit invoices for passenger receipts for reimbursement consideration through Accounts Payable.

   f. 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 Health shall not reimburse the expense.

3. Completed and approved Expense Reports with supporting documentation shall be submitted to the Accounting Department in a timely manner, preferably within thirty (30) days of completion of travel, but in no event beyond sixty (60) days after the expense is paid or incurred. Expense Reports are paid with the next payroll processing cycle and included on the employee's payroll check.

4. No reimbursement shall be made for Expense Reports submitted beyond sixty (60) days after completion of travel or when the expenses were paid or incurred, whichever occurs first.

For 20250807 BOD Review Only

Back to Agenda Back to Item

a. Authorized Individuals may request an exception to the submission deadline, which is subject to the review and approval by the Controller.

D. The Accounting Department shall:

1. Review submitted Expense Reports and supporting documentation for completeness;

a. During the review, Accounting shall contact the Authorized Individual to request any missing supporting documentation.

b. Accounting shall provide advance communication of any denied reimbursement claims.

c. An Authorized Individual may dispute denied reimbursement claims by providing a narrative and/or additional supporting documentation to be reviewed by the Controller.

2. Review expense codes for appropriate department and general ledger account numbers; and

3. Process payment for reimbursement as a non-taxable miscellaneous reimbursement.

E. The Procurement & Vendor Management Department shall:

1. Provide travel reports to the CEO, Executive Staff and department directors, upon request. Such reports may include a summary of travel by department, purpose, cost, and number of Authorized Individuals per event;

2. Review details of statements/invoices received from the CalOptima Health travel services provider for accuracy;

3. Maintain a database of completed TTA forms related to travel service provider invoice line items and shall submit supported monthly invoices to Accounts Payable for payment;

4. Review details of statements/invoices received from the credit card account to arrange attendance at conferences, trainings, and other events, and for making authorized purchases; and

5. Maintain a database of approved credit card invoice travel and training line items and once reviewed, submit the supported invoices to Accounts Payable for payment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Bylaws of Orange County Health Authority dba Orange Prevention and Treatment Integrated Medical Assistance, Adopted December 6, 1994
B. CalOptima Health Policy GA.5003: Budget and Operations Forecasting
C. CalOptima Health Policy GA.8033: License and Certification Tracking
D. CalOptima Health Policy GA.8042: Supplemental Compensation
E. CalOptima Health Policy GA.1223: Participation in Community Events by External Entities
F. Internal Revenue Service Publication 463
G. California Government Code Section 53232.2
H. California Labor Code Section 2802

For 20250807 BOD Review Only

Back to Agenda Back to Item

I. Title 26, Code of Federal Regulations §§ 1.62-2

VI. REGULATORY AGENCY APPROVAL(S)

Not Applicable

VII. BOARD ACTION(S)

Date	Meeting
09/06/2012	Regular Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors
11/02/2023	Regular Meeting of the CalOptima Health Board of Directors
08/07/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2012	GA.5004	Travel Policy	Administrative
Revised	09/06/2012	GA.5004	Travel Policy	Administrative
Revised	03/01/2013	GA.5004	Travel Policy	Administrative
Revised	03/03/2022	GA.5004	Travel Policy	Administrative
Revised	12/01/2022	GA.5004	Travel and Business Meal Policy	Administrative
Revised	11/02/2023	GA.5004	Travel and Other Reimbursable Expenses	Administrative
Revised	10/01/2024	GA.5004	Travel and Other Reimbursable Expenses	Administrative
Revised	07/01/2025	GA.5004	Travel and Other Reimbursable Expenses	Administrative

For 20250807 B

IX. GLOSSARY

Term	Definition
Authorized Individual	Persons authorized to submit an Expense Report for reimbursement of travel, meal, lodging, or other allowable expenses, including: CalOptima Health Board members, CalOptima Health Standing Committee Members, CalOptima Health Employees, and individuals under contract to CalOptima Health for which the approved contract provides for reimbursement of travel and/or conference expenses.
Approved Lodging Facility	Any overnight sleeping facilities which offer a discounted government rate to authorized individuals traveling on behalf of CalOptima Health.
Business Meals	Breakfast, lunch, dinner, snacks, refreshments, and related tips and taxes where business is discussed between authorized CalOptima staff and industry peers or business associates over the course of a meal.
CalOptima Health Business	Activities or functions which a department head determines are directly related to or in support of the ordinary, necessary and/or required mission and business functions of CalOptima Health.
CalOptima Health Employees	Includes, but are not limited to, all full-time and part-time regular CalOptima Health employees, all temporary employees, interns, CalOptima Health Board members, and applicable contractors and consultants.
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.
Executive Staff	Staff holding Executive level positions as designated by the Board of Directors.
Expense Report	Detailed and itemized report that tracks expenses incurred during the course of performing necessary job functions.
Governing Body	The Board of Directors of CalOptima Health.
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Health Board of Directors who provide advice and recommendations regarding the organization's investments.
Local Travel	Travel to a destination that is 50 miles or less away from the primary workplace or home and does not generally include an overnight stay.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Non-local Travel	Travel which is more than 50 miles away from the primary workplace or home and may require an overnight stay.
Non-Reimbursable Expenses	Expenses that are not a necessary part of or approved as part of the required travel. Commuting between a traveler's home and regularly assigned work location is not considered official business.
Parking, Fees and Tolls	Charges for ferries, bridges, tunnels, toll roads, and necessary parking.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima Health to advise its Board of Directors on issues impacting the CalOptima Health Provider community.

For 20250907 BOD Review Only

Back to Agenda Back to Item

Term	Definition
Registration Fees	Actual fees paid for registration to attend authorized conferences, seminars, conventions, trainings or meetings of professional societies or community organizations.
Reimbursable Expenses	Reimbursable expenses include but are not limited to the cost of travel, transportation, catering and meals, lodging, business-related professional licenses and membership dues, public activities, and other actual and necessary business -related expenses incurred by CalOptima Health Employees, Governing Body, Standing Committee Members, and authorized contractors and consultants while conducting authorized CalOptima Health Business.
Standing Committee Members	Non-Board and non-employee members of the CalOptima Health Investment Advisory Committee (IAC), Provider Advisory Committee (PAC), Member Advisory Committee (MAC), OneCare Connect MAC, and Whole Child Model Family Advisory Committee.
Transportation	Bus, rail or airfare, car rental, taxi, ride sharing, shuttle, parking fees, tolls, and mileage for use of personal vehicle.
Travel Meals	Travel Meals are those food items consumed when traveling on CalOptima Health business that is considered Non-local Travel.

For 20250807 BOD Review Only

Back to Agenda Back to Item

CalOptima Health

Financial Summary
May 31, 2025

Board of Directors Meeting

August 7, 2025

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Financial Highlights
May 2025

May 2025					July 2024 - May 2025			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
904,822	902,551	2,271	0.3%	Member Months	10,020,773	9,910,830	109,943	1.1%
383,705,667	360,140,925	23,564,742	6.5%	Revenues	4,643,870,625	3,932,379,474	711,491,151	18.1%
362,648,160	358,365,028	(4,283,132)	(1.2%)	Medical Expenses	4,293,978,939	3,903,555,385	(390,423,554)	(10.0%)
23,196,331	25,970,983	2,774,652	10.7%	Administrative Expenses	232,721,195	273,160,052	40,438,857	14.8%
(2,138,824)	**(24,195,086)**	**22,056,262**	**91.2%**	**Operating Margin**	**117,170,491**	**(244,335,963)**	**361,506,454**	**148.0%**
				Non-Operating Income (Loss)				
6,546,500	6,666,660	(120,160)	(1.8%)	Net Investment Income/Expense	175,877,753	73,333,260	102,544,493	139.8%
(39,341)	(117,280)	77,939	66.5%	Net Rental Income/Expense	(416,483)	(1,290,080)	873,597	67.7%
49,764	-	49,764	100.0%	Net MCO Tax	5,633,875	-	5,633,875	100.0%
(23,976)	(1,178,825)	1,154,849	98.0%	Grant Expense	(14,252,923)	(12,876,166)	(1,376,757)	(10.7%)
(8,537)	-	(8,537)	(100.0%)	Other Income/Expense	(6,328)	-	(6,328)	(100.0%)
6,524,410	**5,370,555**	**1,153,855**	**21.5%**	**Total Non-Operating Income (Loss)**	**166,835,894**	**59,167,014**	**107,668,880**	**182.0%**
4,385,585	**(18,824,531)**	**23,210,116**	**123.3%**	**Change in Net Assets**	**284,006,385**	**(185,168,949)**	**469,175,334**	**253.4%**
94.5%	*99.5%*	*(5.0%)*		*Medical Loss Ratio*	*92.5%*	*99.3%*	*(6.8%)*	
6.0%	*7.2%*	*1.2%*		*Administrative Loss Ratio*	*5.0%*	*6.9%*	*1.9%*	
(0.6%)	*(6.7%)*	*6.2%*		*Operating Margin Ratio*	*2.5%*	*(6.2%)*	*8.7%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
90.0%	*94.6%*	*(4.7%)*		**Adjusted MLR*	*86.3%*	*94.4%*	*(8.1%)*	
6.0%	*7.2%*	*1.2%*		**Adjusted ALR*	*5.5%*	*6.9%*	*1.5%*	

*Adjusted MLR /ALR excludes estimated Board-approved Provider Rate increases, Directed Payments and Community Reinvestment Accruals, but includes costs associated with CalOptima Health's Digital Transformation Strategy (DTS) budget.

CalOptima Health

Financial Highlights Notes: May 2025

- Notable events/items in May 2025
  - $3.4 million net reduction to OneCare LOB due to Calendar Year (CY) 2024 Hierarchical Condition Category (HCC) annual true-up
  - Lower than average net investment income in May due to higher interest rates that resulted in a reduction of the net unrealized gains
  - Favorable revenue due primarily to:
    - The revised CY 2025 draft rates received in December were favorable compared to budget assumptions. Staff anticipates that additional rates amendments are forthcoming from the Department of Health Care Services (DHCS) due to program and member acuity changes

CalOptima Health

FY 2024-25: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) May 2025: $4.4 million, favorable to budget $23.2 million or 123.3% primarily due to:
    - Medi-Cal (MC) enrollment and CY 2025 premium capitation rates offset by higher claims utilization
  - Year To Date (YTD) July 2024 – May 2025: $284.0 million, favorable to budget $469.2 million or 253.4% primarily due to:
    - Favorable net investment income, premium capitation rates and enrollment in the MC Line of Business (LOB)

CalOptima Health

FY 2024-25 Management Summary (cont.)

- Enrollment
  - MTD: 904,822 members, favorable to budget 2,271 or 0.3%
  - YTD: 10,020,773 member months, favorable to budget 109,943 or 1.1%

FY 2024-25 Management Summary (cont.)

- Revenue
  - MTD: $383.7 million, favorable to budget $23.6 million or 6.50% driven by:
    - $35.6 million in MC LOB due to favorable enrollment and CY 2025 premium capitation rates
    - Offset by $13.0 million in OneCare (OC) LOB due to less risk adjustable data for CY 2024 HCC compared to prior year
  - YTD: $4,643.9 million, favorable to budget $711.5 million or 18.1% driven by:
    - MC LOB due to favorable enrollment, premium capitation rates, and CY 2022 and 2023 Hospital Directed Payments (DP)

CalOptima Health

FY 2024-25 Management Summary (cont.)

- Medical Expenses
  - MTD: $362.7 million, unfavorable to budget $4.3 million or 1.2% driven by:
    - $16.9 million unfavorable variances in MC due to:
      - $13.1 million in Facilities, Professional, and MLTSS claims due to increased utilization
      - $3.9 million in Provider Capitation
    - Offset by favorable variances in OC due to:
      - $10.0 million in Provider Capitation due to changes in CY 2024 HCC estimates
      - $1.2 million in Prescription Drug expenses

CalOptima Health

FY 2024-25 Management Summary (cont.)

- Medical Expenses (cont.)
  - YTD: $4,294.0 million, unfavorable to budget $390.4 million or 10.0% driven by:
    - $421.3 million in MC Other Medical Expense due primarily to CY 2022 and 2023 Hospital DP, Community Reinvestment, and Quality Achievement accruals.
    - Offset by $13.5 million in MC Incentive Payments expense due to Hospital Quality Program (HQP)

FY 2024-25 Management Summary (cont.)

- Administrative Expenses
  - MTD: $23.2 million, favorable to budget $2.8 million or 10.7%
  - YTD: $232.7 million, favorable to budget $40.4 million or 14.8%

FY 2024-25 Management Summary (cont.)

- Non-Operating Income (Loss)
  - MTD: $6.5 million, favorable to budget $1.2 million or 21.5% primarily due to favorable Grant Expense of $1.2 million
  - YTD: $166.8 million, favorable to budget $107.7 million or 182.0% primarily due to favorable Net Investment income of $102.5 million and favorable Net Managed Care Organization (MCO) tax of $5.6 million

FY 2024-25: Key Financial Ratios

- Medical Loss Ratio (MLR)

		Actual	Budget	Variance (%)
MTD	MLR	94.5%	99.5%	(5.0%)
	Adjusted MLR*	90.0%	94.6%	(4.7%)
YTD	MLR	92.5%	99.3%	(6.8%)
	Adjusted MLR*	86.3%	94.4%	(8.1%)

- Administrative Loss Ratio (ALR)

		Actual	Budget	Variance (%)
MTD	ALR	6.0%	7.2%	1.2%
	Adjusted ALR*	6.0%	7.2%	1.2%
YTD	ALR	5.0%	6.9%	1.9%
	Adjusted ALR*	5.5%	6.9%	1.5%

* Adjusted MLR/ALR excludes estimated Board-approved Provider Rate Increases, Directed Payments and Community Reinvestment Accruals, but include costs associated with DTS.

CalOptima Health

FY 2024:25: Key Financials Ratios (cont.)

- Balance Sheet Ratios
  - Current ratio*: 1.7
  - Board Designated Reserve level: 3.86
  - Statutory Designated Reserve level: 1.02
  - Net-position: $2.7 billion, including required TNE of $129.0 million

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

Enrollment Summary: May 2025

May 2025					July 2024 - May 2025			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
151,247	139,052	12,195	8.8%	SPD	1,619,003	1,512,712	106,291	7.0%
260,096	272,043	(11,947)	(4.4%)	TANF Child	2,925,386	2,994,506	(69,120)	(2.3%)
129,052	138,555	(9,503)	(6.9%)	TANF Adult	1,436,884	1,519,224	(82,340)	(5.4%)
2,584	2,596	(12)	(0.5%)	LTC	27,487	28,632	(1,145)	(4.0%)
335,128	322,733	12,395	3.8%	MCE	3,712,736	3,553,571	159,165	4.5%
8,723	9,543	(820)	(8.6%)	WCM	104,034	105,082	(1,048)	(1.0%)
886,830	**884,522**	**2,308**	**0.3%**	**Medi-Cal Total**	**9,825,530**	**9,713,727**	**111,803**	**1.2%**
17,476	**17,537**	**(61)**	**(0.3%)**	**OneCare**	**189,692**	**191,822**	**(2,130)**	**(1.1%)**
516	**492**	**24**	**4.9%**	**PACE**	**5,551**	**5,281**	**270**	**5.1%**
544	**568**	**(24)**	**(4.2%)**	**MSSP***	**5,674**	**6,248**	**(574)**	**(9.2%)**
904,822	**902,551**	**2,271**	**0.3%**	**CalOptima Health Total**	**10,020,773**	**9,910,830**	**109,943**	**1.1%**

*MSSP enrollment is included in Medi-Cal Total

CalOptima Health

Consolidated Revenue & Expenses: May 2025 MTD

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	886,830	17,476		516	544		904,822
REVENUES							
Capitation Revenue	$ 355,216,686	$ 23,142,943	$ -	$ 5,090,247	$ 255,790	$ -	$ 383,705,667
Total Operating Revenue	**355,216,686**	**23,142,943**	**-**	**5,090,247**	**255,790**	**-**	**383,705,667**
MEDICAL EXPENSES							
Provider Capitation	115,343,244	6,190,005					121,533,250
Claims	143,801,097	6,324,474		2,076,584			152,202,155
MLTSS	55,797,519			21,967	49,875		55,869,362
Prescription Drugs		8,146,505		561,367			8,707,872
Case Mgmt & Other Medical	21,258,923	1,561,509		1,321,459	193,632		24,335,523
Total Medical Expenses	**336,200,783**	**22,222,492**	**-**	**3,981,378**	**243,508**	**-**	**362,648,160**
Medical Loss Ratio	*94.6%*	*96.0%*	*0.0%*	*78.2%*	*95.2%*	*0.0%*	*94.5%*
GROSS MARGIN	**19,015,903**	**920,451**	**-**	**1,108,870**	**12,282**	**-**	**21,057,506**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	12,074,631	1,020,699		184,441	104,739		13,384,510
Non-Salary Operating Expenses	3,204,305	822,829		127,606	1,422	457,315	4,613,478
Depreciation & Amortization	1,521,271			991			1,522,262
Other Operating Expenses	3,235,719	73,946		7,080	6,910		3,323,656
Indirect Cost Allocation, Occupancy	(707,670)	1,036,392		16,899	6,804		352,426
Total Administrative Expenses	**19,328,257**	**2,953,866**	**-**	**337,017**	**119,875**	**457,315**	**23,196,331**
Administrative Loss Ratio	*5.4%*	*12.8%*	*0.0%*	*6.6%*	*46.9%*	*0.0%*	*6.0%*
Operating Income/(Loss)	**(312,354)**	**(2,033,415)**	**-**	**771,852**	**(107,593)**	**(457,315)**	**(2,138,824)**
Investments and Other Non-Operating	41,227						6,524,410
CHANGE IN NET ASSETS	**$ (271,127)**	**$ (2,033,415)**	**$ -**	**$ 771,852**	**$ (107,593)**	**$ (457,315)**	**$ 4,385,585**
BUDGETED CHANGE IN NET ASSETS	(21,482,755)	(1,550,407)	-	(128,235)	(117,023)	(916,666)	(18,824,531)
Variance to Budget - Fav/(Unfav)	$ 21,211,628	$ (483,008)	$ -	$ 900,087	$ 9,430	$ 459,351	$ 23,210,116

CalOptima Health

Consolidated Revenue & Expenses: May 2025 YTD

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	9,825,530	189,692		5,551	5,674		10,020,773
REVENUES							
Capitation Revenue	$ 4,221,729,015	$ 373,008,676	$ (3,197,365)	$ 49,731,234	$ 2,599,065	$ -	$ 4,643,870,625
Total Operating Revenue	**4,221,729,015**	**373,008,676**	**(3,197,365)**	**49,731,234**	**2,599,065**	**-**	**4,643,870,625**
MEDICAL EXPENSES							
Provider Capitation	1,254,346,788	154,536,635	(1,453,037)				1,407,430,387
Claims	1,452,569,602	67,606,521	(184,151)	18,200,081			1,538,192,052
MLTSS	542,795,927			216,193	433,345		543,445,464
Prescription Drugs		99,430,282		6,432,704			105,862,986
Case Mgmt & Other Medical	663,051,958	19,904,048		14,023,068	2,068,976		699,048,050
Total Medical Expenses	**3,912,764,275**	**341,477,486**	**(1,637,188)**	**38,872,046**	**2,502,321**	**-**	**4,293,978,939**
Medical Loss Ratio	*92.7%*	*91.5%*	*51.2%*	*78.2%*	*96.3%*	*0.0%*	*92.5%*
GROSS MARGIN	**308,964,740**	**31,531,191**	**(1,560,177)**	**10,859,188**	**96,744**	**-**	**349,891,686**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	126,578,854	11,773,426		1,882,220	1,131,915		141,366,415
Non-Salary Operating Expenses	38,361,498	6,628,730		934,899	15,630	665,034	46,605,791
Depreciation & Amortization	8,690,126			10,711			8,700,837
Other Operating Expenses	30,998,830	932,002		100,027	84,862		32,115,721
Indirect Cost Allocation, Occupancy	(8,446,939)	12,105,474		192,953	80,944		3,932,431
Total Administrative Expenses	**196,182,370**	**31,439,631**	**-**	**3,120,809**	**1,313,351**	**665,034**	**232,721,195**
Administrative Loss Ratio	*4.6%*	*8.4%*	*0.0%*	*6.3%*	*50.5%*	*0.0%*	*5.0%*
Operating Income/(Loss)	**112,782,370**	**91,560**	**(1,560,177)**	**7,738,379**	**(1,216,607)**	**(665,034)**	**117,170,491**
Investments and Other Non-Operating	5,627,547						166,835,894
CHANGE IN NET ASSETS	**$ 118,409,918**	**$ 91,560**	**$ (1,560,177)**	**$ 7,738,379**	**$ (1,216,607)**	**$ (665,034)**	**$ 284,006,385**
BUDGETED CHANGE IN NET ASSETS	(225,881,958)	(11,696,869)	-	(926,509)	(1,247,297)	(4,583,330)	(185,168,949)
Variance to Budget - Fav/(Unfav)	$ 344,291,876	$ 11,788,429	$ (1,560,177)	$ 8,664,888	$ 30,690	$ 3,918,296	$ 469,175,334

CalOptima Health

Balance Sheet: As of May 2025

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$585,417,907	Accounts Payable	$169,146,029
Short-term Investments	1,306,481,200	Medical Claims Liability	1,118,595,383
Capitation Receivable	595,472,115	Accrued Payroll Liabilities	20,192,220
Receivables - Other	93,591,246	Deferred Revenue	52,706,769
Prepaid Expenses	14,208,216	Other Current Liabilities	-
Total Current Assets	**2,595,170,684**	Capitation and Withholds	147,550,408
		Total Current Liabilities	**1,508,190,809**
Capital Assets			
Capital Assets	189,811,876	**Other Liabilities**	
Less Accumulated Depreciation	(91,283,559)	GASB 96 Subscription Liabilities	17,058,702
Capital Assets, Net of Depreciation	**98,528,317**	Community Reinvestment	148,058,180
		Capital Lease Payable	249,289
		Postemployment Health Care Plan	17,729,256
Other Assets		Net Pension Liabilities	45,981,359
Restricted Deposits	300,000	**Total Other Liabilities**	**229,076,787**
Board Designated Reserves	1,573,812,290		
Statutory Designated Reserves	131,292,301	**TOTAL LIABILITIES**	
Total Other Assets	**1,705,404,591**		**1,737,267,595**
TOTAL ASSETS	**4,399,103,592**	**Deferred Inflows**	**8,646,445**
Deferred Outflows	**75,899,007**	**Net Position**	
		Required TNE	129,014,190
		Funds in Excess of TNE	2,600,074,369
		TOTAL NET POSITION	**2,729,088,559**
TOTAL ASSETS & DEFERRED OUTFLOWS	**4,475,002,599**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**4,475,002,599**

CalOptima Health

Board Designated Reserve and TNE Analysis: As of May 2025

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	786,976,185				
MetLife Tier One	786,836,105				
Board Designated Reserves	1,573,812,290	1,018,934,643	1,630,295,429	554,877,647	(56,483,139)
Current Reserve Level (X months of average monthly revenue) [1]	*3.86*	*2.50*	*4.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	65,769,930				
MetLife Tier Two	65,522,371				
Statutory Designated Reserves	131,292,301	129,014,190	141,915,610	2,278,111	(10,623,308)
Current Reserve Level (X min. TNE) [1]	*1.02*	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

CalOptima Health

Spending Plan: As of May 2025

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @5/31/2025	**$2,729.1**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,573.8**			**57.7%**
	Statutory Designated Reserve[1]	**$131.3**			**4.8%**
	Capital Assets, net of Depreciation	**$98.5**			**3.6%**
Resources Allocated[3]	Homeless Health Initiative[2]	$18.6	$66.0	$47.4	0.7%
	Housing and Homelessness Incentive Program[2]	21.9	87.4	65.5	0.8%
	Intergovernmental Transfers (IGT)[4]	54.1	111.7	57.6	2.0%
	Digital Transformation and Workplace Modernization[3]	33.5	100.0	66.5	1.2%
	CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
	CalFresh and Redetermination Outreach Strategy	1.8	6.0	4.2	0.1%
	Coalition of Orange County Community Health Centers Grant	20.0	50.0	30.0	0.7%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives[4]	0.2	0.5	0.3	0.0%
	General Awareness Campaign	0.9	4.7	3.8	0.0%
	Member Health Needs Assessment	0.9	1.3	0.4	0.0%
	Five-Year Hospital Quality Program Beginning MY 2022	121.7	153.5	31.8	4.5%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.4%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program Grant	3.5	5.0	1.5	0.1%
	Community Living and PACE center (previously approved for project located in Tustin)[4]	17.2	18.0	0.8	0.6%
	Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program Grant	1.5	2.7	1.2	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	44.5	50.0	5.5	1.6%
	Distribution Event - Naloxone Grant	2.2	15.0	12.8	0.1%
	Garden Grove Bldg. Improvement	10.0	10.5	0.5	0.4%
	Post-Pandemic Supplemental[4]	6.0	107.5	101.5	0.2%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.4%
	Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
	Outreach Strategy for newly eligible Adult Expansion members	3.4	7.6	4.2	0.1%
	Quality Initiatives from unearned Pay for Value Program	18.8	23.3	4.5	0.7%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.3	1.2	0.9	0.0%
	Medi-Cal Provider Rate Increases	333.3	526.2	192.9	12.2%
	Homeless Prevention and Stabilization Pilot Program	0.3	0.3	0.0	0.0%
	OneCare Member Engagement and Education	0.3	0.3	0.0	0.0%
	Subtotal:	**$765.8**	**$1,422.5**	**$656.7**	**28.1%**
Resources Available for I	Unallocated/Unassigned[1]	**$159.6**			**5.8%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 160 days of CalOptima Health's current operations.

[2] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.

[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

[4] On June 5, 2025, the Board of Directors approved the close out of Board-approved initiatives and transfer of remaining funds back to unallocated reserves.

CalOptima Health

Homeless Health Initiative and Allocated Funds: As of May 2025

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Days, HCAP and FQHC Administrative Support	963,261	913,595	49,666
FQHC (Community Health Center) Expansion	21,902	21,902	-
Homeless Clinical Access Program (HCAP) and CalOptima Days	9,888,914	4,334,952	5,553,962
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine	14,376,652	7,396,757	6,979,895
Outreach and Engagement	7,000,000	1,138,008	5,861,992
Housing and Homelessness Incentive Program (HHIP)*	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 106,100,000**	**$ 47,442,264**	**$ 58,657,736**
Transfer of funds to HHIP*	(40,100,000)	-	(40,100,000)
Program Total	**$ 66,000,000**	**$ 47,442,264**	**$ 18,557,736**

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

*On March 19, 2025, CalOptima Health's Board of Directors approved $9.3 million to expand the Street Medicine Program - $3.2 million remaining from Street Medicine Initiative (from the Homeless Health Initiatives Reserve), $6.1 million from Existing Reserves to fund 2-year grant agreements to Healthcare in Action (Anaheim), Celebrating Life Community Health Center (Costa Mesa), and a new Street Medicine provider (Santa Ana).

CalOptima Health

Housing and Homelessness Incentive Program: As of May 2025

Summary By Funding Source	Total Funds	Allocated Amount	Amount Spent	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	54,930,994	30,916,048	24,014,946	18,000,195
Existing Reserves and HHI Transfer	87,384,530	87,384,530	65,528,126	21,856,404	-
Total	**160,315,719**	**142,315,524**	**96,444,174**	**45,871,351**	**18,000,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	847,350	552,650	HHI
Equity Grants for Programs Serving Underrepr	4,621,311	3,621,311	1,000,001	HHI & DHCS
Infrastructure Projects	5,832,314	5,580,354	251,960	HHI
Capital Projects	108,247,369	77,195,575	31,051,794	HHI & DHCS & Existing Reserves
System Change Projects	10,184,530	6,344,193	3,840,337	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	**$ 133,185,524** [1]	**$ 96,444,174**	**$ 36,741,351**	

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from Homeless Health Initiatives, $47.2 million from CalOptima Health Existing Reserves, and $73 million from DHCS Housing and Homeless Incentive Program payments.

CalOptima Health

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UNAUDITED FINANCIAL STATEMENTS

May 31, 2025

Back to Agenda

Table of Contents

Financial Highlights 3
Full-Time Equivalent (FTE) Data 4
Statement of Revenues and Expenses – Consolidated Month to Date 5
Statement of Revenues and Expenses – Consolidated Year to Date 6
Statement of Revenues and Expenses by LOB – Consolidated Month to Date 7
Statement of Revenues and Expenses by LOB – Consolidated Year to Date 8
Highlights – Consolidated 9
Enrollment Summary 10
Enrollment Trend by Network 11
Highlights – Enrollment 12
Statement of Revenues and Expenses – Medi-Cal 13
Highlights – Medi-Cal 14
Statement of Revenues and Expenses – OneCare 15
Highlights – OneCare 16
Statement of Revenues and Expenses – PACE 17
Statement of Revenues and Expenses – MSSP 18
Statement of Revenues and Expenses – OneCare Connect 19
Statement of Revenues and Expenses – Covered CA 20
Statement of Revenues and Expenses – 505 City Parkway 21
Statement of Revenues and Expenses – 500 City Parkway 22
Statement of Revenues and Expenses – 7900 Garden Grove Blvd 23
Highlights – PACE, MSSP, OneCare Connect, Covered CA, 505 & 500 City Parkway and 7900 Garden Grove Blvd 24
Balance Sheet 25
Highlights – Balance Sheet 26
Board Designated Reserve and, TNE Analysis 27
Statement of Cash Flow 28
Spending Plan 29
Key Financial Indicators 30
Digital Transformation Strategy 31
Homeless Health Initiatives 32
Housing and Homelessness Incentive Program 33
Budget Allocation Changes 34

Back to Agenda

CalOptima Health - Consolidated
Financial Highlights
For the Eleven Months Ending May 31, 2025

May 2025					July 2024 - May 2025			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
904,822	902,551	2,271	0.3%	Member Months	10,020,773	9,910,830	109,943	1.1%
383,705,667	360,140,925	23,564,742	6.5%	Revenues	4,643,870,625	3,932,379,474	711,491,151	18.1%
362,648,160	358,365,028	(4,283,132)	(1.2%)	Medical Expenses	4,293,978,939	3,903,555,385	(390,423,554)	(10.0%)
23,196,331	25,970,983	2,774,652	10.7%	Administrative Expenses	232,721,195	273,160,052	40,438,857	14.8%
(2,138,824)	**(24,195,086)**	**22,056,262**	**91.2%**	**Operating Margin**	**117,170,491**	**(244,335,963)**	**361,506,454**	**148.0%**
				Non-Operating Income (Loss)				
6,546,500	6,666,660	(120,160)	(1.8%)	Net Investment Income/Expense	175,877,753	73,333,260	102,544,493	139.8%
(39,341)	(117,280)	77,939	66.5%	Net Rental Income/Expense	(416,483)	(1,290,080)	873,597	67.7%
49,764	-	49,764	100.0%	Net MCO Tax	5,633,875	-	5,633,875	100.0%
(23,976)	(1,178,825)	1,154,849	98.0%	Grant Expense	(14,252,923)	(12,876,166)	(1,376,757)	(10.7%)
(8,537)	-	(8,537)	(100.0%)	Other Income/Expense	(6,328)	-	(6,328)	(100.0%)
6,524,410	**5,370,555**	**1,153,855**	**21.5%**	**Total Non-Operating Income (Loss)**	**166,835,894**	**59,167,014**	**107,668,880**	**182.0%**
4,385,585	**(18,824,531)**	**23,210,116**	**123.3%**	**Change in Net Assets**	**284,006,385**	**(185,168,949)**	**469,175,334**	**253.4%**
94.5%	*99.5%*	*(5.0%)*		*Medical Loss Ratio*	*92.5%*	*99.3%*	*(6.8%)*	
6.0%	*7.2%*	*1.2%*		*Administrative Loss Ratio*	*5.0%*	*6.9%*	*1.9%*	
(0.6%)	*(6.7%)*	*6.2%*		*Operating Margin Ratio*	*2.5%*	*(6.2%)*	*8.7%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
90.0%	*94.6%*	*(4.7%)*		**Adjusted MLR*	*86.3%*	*94.4%*	*(8.1%)*	
6.0%	*7.2%*	*1.2%*		**Adjusted ALR*	*5.5%*	*6.9%*	*1.5%*	

*Adjusted MLR /ALR excludes estimated Board-approved Provider Rate increases, Directed Payments and Community Reinvestment Accruals, but includes costs associated with CalOptima Health's Digital Transformation Strategy (DTS) budget.

Back to Agenda

CalOptima Health - Consolidated
Full Time Equivalent (FTE) Data
For the Eleven Months Ending May 31, 2025

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1,326	1,361	35
OneCare	166	186	20
PACE	110	113	3
MSSP	23	25	2
Total	1,624	1,685	61

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	14,371	14,969	598
OneCare	1,877	2,047	170
PACE	1,178	1,243	65
MSSP	237	275	38
Total	17,663	18,533	871

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	669	650	(19)
OneCare	105	94	(11)
PACE	5	4	(1)
MSSP	24	23	(1)
Consolidated	557	536	(21)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	684	649	(35)
OneCare	101	94	(7)
PACE	5	4	(1)
MSSP	24	23	(1)
Consolidated	567	535	(32)

Open FTE			
	Total	Medical	Admin
Medi-Cal	63	27	36
OneCare	11	8	3
PACE	9	9	0
MSSP	0	0	0
Total	83	44	39

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending May 31, 2025

MEMBER MONTHS		904,822		902,551		2,271
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$355,216,686	$400.55	$319,658,819	$361.39	$35,557,867	$39.16
OneCare	23,142,943	1,324.27	36,102,771	2,058.66	(12,959,828)	(734.39)
PACE	5,090,247	9,864.82	4,125,818	8,385.81	964,429	1,479.01
MSSP	255,790	470.20	253,517	446.33	2,273	23.87
Total Operating Revenue	383,705,667	424.07	360,140,925	399.03	23,564,742	25.04
MEDICAL EXPENSES						
Medi-Cal	336,200,783	379.10	319,801,076	361.55	(16,399,707)	(17.55)
OneCare	22,222,492	1,271.60	34,372,747	1,960.01	12,150,255	688.41
PACE	3,981,378	7,715.85	3,950,464	8,029.40	(30,914)	313.55
MSSP	243,508	447.62	240,741	423.84	(2,767)	(23.78)
Total Medical Expenses	362,648,160	400.80	358,365,028	397.06	(4,283,132)	(3.74)
GROSS MARGIN	21,057,506	23.27	1,775,897	1.97	19,281,609	21.30
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	13,384,510	14.79	13,917,865	15.42	533,355	0.63
Professional Fees	1,515,788	1.68	2,931,111	3.25	1,415,324	1.57
Purchased Services	2,588,212	2.86	3,232,130	3.58	643,918	0.72
Printing & Postage	509,478	0.56	657,295	0.73	147,817	0.17
Depreciation & Amortization	1,522,262	1.68	1,027,958	1.14	(494,304)	(0.54)
Other Expenses	3,323,656	3.67	3,760,631	4.17	436,975	0.50
Indirect Cost Allocation, Occupancy	352,426	0.39	443,993	0.49	91,567	0.10
Total Administrative Expenses	23,196,331	25.64	25,970,983	28.78	2,774,652	3.14
NET INCOME (LOSS) FROM OPERATIONS	(2,138,824)	(2.36)	(24,195,086)	(26.81)	22,056,262	24.45
INVESTMENT INCOME						
Interest Income	13,964,000	15.43	6,666,660	7.39	7,297,340	8.04
Realized Gain/(Loss) on Investments	449,606	0.50	-	-	449,606	0.50
Unrealized Gain/(Loss) on Investments	(7,867,106)	(8.69)	-	-	(7,867,106)	(8.69)
Total Investment Income	6,546,500	7.24	6,666,660	7.39	(120,160)	(0.15)
NET RENTAL INCOME/EXPENSE	(39,341)	(0.04)	(117,280)	(0.13)	77,939	0.09
NET MCO TAX	49,764	0.05	-	-	49,764	0.05
GRANT EXPENSE	(23,976)	(0.03)	(1,178,825)	(1.31)	1,154,849	1.28
OTHER INCOME/EXPENSE	(8,537)	(0.01)	-	-	(8,537)	(0.01)
CHANGE IN NET ASSETS	**4,385,585**	**4.85**	**(18,824,531)**	**(20.86)**	**23,210,116**	**25.71**
MEDICAL LOSS RATIO	**94.5%**		**99.5%**		**(5.0%)**	
ADMINISTRATIVE LOSS RATIO	**6.0%**		**7.2%**		**1.2%**	

Back to Agenda

CalOptima Health- Consolidated - Year to Date
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2025

MEMBER MONTHS		10,020,773		9,910,830		109,943
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$4,221,729,015	$429.67	$3,494,906,566	$359.79	$726,822,449	$69.88
OneCare	373,008,676	1,966.39	390,615,552	2,036.34	(17,606,876)	(69.95)
OneCare Connect	(3,197,365)		-		(3,197,365)	0.00
PACE	49,731,234	8,958.97	44,068,669	8,344.76	5,662,565	614.21
MSSP	2,599,065	458.07	2,788,687	446.33	(189,622)	11.74
Total Operating Revenue	4,643,870,625	463.42	3,932,379,474	396.78	711,491,151	66.64
MEDICAL EXPENSES						
Medi-Cal	3,912,764,275	398.22	3,492,267,927	359.52	(420,496,348)	(38.70)
OneCare	341,477,486	1,800.17	366,915,051	1,912.79	25,437,565	112.62
OneCare Connect	(1,637,188)				1,637,188	0.00
PACE	38,872,046	7,002.71	41,724,256	7,900.82	2,852,210	898.11
MSSP	2,502,321	441.02	2,648,151	423.84	145,830	(17.18)
Total Medical Expenses	4,293,978,939	428.51	3,903,555,385	393.87	(390,423,554)	(34.64)
GROSS MARGIN	349,891,686	34.91	28,824,089	2.91	321,067,597	32.00
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	141,366,415	14.11	148,715,390	15.01	7,348,975	0.90
Professional Fees	15,098,938	1.51	23,473,803	2.37	8,374,865	0.86
Purchased Services	25,860,392	2.58	33,513,793	3.38	7,653,400	0.80
Printing & Postage	5,646,461	0.56	8,435,522	0.85	2,789,061	0.29
Depreciation & Amortization	8,700,837	0.87	11,307,538	1.14	2,606,702	0.27
Other Expenses	32,115,721	3.20	42,833,134	4.32	10,717,413	1.12
Indirect Cost Allocation, Occupancy	3,932,431	0.39	4,880,873	0.49	948,442	0.10
Total Administrative Expenses	232,721,195	23.22	273,160,052	27.56	40,438,857	4.34
NET INCOME (LOSS) FROM OPERATIONS	117,170,491	11.69	(244,335,963)	(24.65)	361,506,454	36.34
INVESTMENT INCOME						
Interest Income	158,742,876	15.84	73,333,260	7.40	85,409,616	8.44
Realized Gain/(Loss) on Investments	5,140,210	0.51	-	0.00	5,140,210	0.51
Unrealized Gain/(Loss) on Investments	11,994,667	1.20	-	0.00	11,994,667	1.20
Total Investment Income	175,877,753	17.55	73,333,260	7.40	102,544,493	10.15
NET RENTAL INCOME/EXPENSE	(416,483)	(0.04)	(1,290,080)	(0.13)	873,597	0.09
NET MCO TAX	5,633,875	0.56	-	0.00	5,633,875	0.56
GRANT EXPENSE	(14,252,923)	(1.42)	(12,876,166)	(1.30)	(1,376,757)	(0.12)
OTHER INCOME/EXPENSE	(6,328)	0.00	-	0.00	(6,328)	0.00
CHANGE IN NET ASSETS	**284,006,385**	**28.34**	**(185,168,949)**	**(18.68)**	**469,175,334**	**47.02**
MEDICAL LOSS RATIO	**92.5%**		**99.3%**		**(6.8%)**	
ADMINISTRATIVE LOSS RATIO	**5.0%**		**6.9%**		**1.9%**	

Back to Agenda

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending May 31, 2025

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	886,830	17,476		516	544	-	904,822
REVENUES							
Capitation Revenue	$ 355,216,686	$ 23,142,943	$ -	$ 5,090,247	$ 255,790	$ -	$ 383,705,667
Total Operating Revenue	**355,216,686**	**23,142,943**	**-**	**5,090,247**	**255,790**	**-**	**383,705,667**
MEDICAL EXPENSES							
Provider Capitation	115,343,244	6,190,005					121,533,250
Claims	143,801,097	6,324,474		2,076,584			152,202,155
MLTSS	55,797,519			21,967	49,875		55,869,362
Prescription Drugs		8,146,505		561,367			8,707,872
Case Mgmt & Other Medical	21,258,923	1,561,509		1,321,459	193,632		24,335,523
Total Medical Expenses	**336,200,783**	**22,222,492**	**-**	**3,981,378**	**243,508**	**-**	**362,648,160**
Medical Loss Ratio	*94.6%*	*96.0%*	*0.0%*	*78.2%*	*95.2%*	*0.0%*	*94.5%*
GROSS MARGIN	**19,015,903**	**920,451**	**-**	**1,108,870**	**12,282**	**-**	**21,057,506**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	12,074,631	1,020,699		184,441	104,739		13,384,510
Non-Salary Operating Expenses	3,204,305	822,829		127,606	1,422	457,315	4,613,478
Depreciation & Amortization	1,521,271			991			1,522,262
Other Operating Expenses	3,235,719	73,946		7,080	6,910		3,323,656
Indirect Cost Allocation, Occupancy	(707,670)	1,036,392		16,899	6,804		352,426
Total Administrative Expenses	**19,328,257**	**2,953,866**	**-**	**337,017**	**119,875**	**457,315**	**23,196,331**
Administrative Loss Ratio	*5.4%*	*12.8%*	*0.0%*	*6.6%*	*46.9%*	*0.0%*	*6.0%*
Operating Income/(Loss)	**(312,354)**	**(2,033,415)**	**-**	**771,852**	**(107,593)**	**(457,315)**	**(2,138,824)**
Investments and Other Non-Operating	41,227						6,524,410
CHANGE IN NET ASSETS	**$ (271,127)**	**$ (2,033,415)**	**$ -**	**$ 771,852**	**$ (107,593)**	**$ (457,315)**	**$ 4,385,585**
BUDGETED CHANGE IN NET ASSETS	(21,482,755)	(1,550,407)	-	(128,235)	(117,023)	(916,666)	(18,824,531)
Variance to Budget - Fav/(Unfav)	$ 21,211,628	$ (483,008)	$ -	$ 900,087	$ 9,430	$ 459,351	$ 23,210,116

Back to Agenda

CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Eleven Months Ending May 31, 2025

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	9,825,530	189,692		5,551	5,674	-	10,020,773
REVENUES							
Capitation Revenue	$ 4,221,729,015	$ 373,008,676	$ (3,197,365)	$ 49,731,234	$ 2,599,065	$ -	$ 4,643,870,625
Total Operating Revenue	**4,221,729,015**	**373,008,676**	**(3,197,365)**	**49,731,234**	**2,599,065**	**-**	**4,643,870,625**
MEDICAL EXPENSES							
Provider Capitation	1,254,346,788	154,536,635	(1,453,037)				1,407,430,387
Claims	1,452,569,602	67,606,521	(184,151)	18,200,081			1,538,192,052
MLTSS	542,795,927			216,193	433,345		543,445,464
Prescription Drugs		99,430,282		6,432,704			105,862,986
Case Mgmt & Other Medical	663,051,958	19,904,048		14,023,068	2,068,976		699,048,050
Total Medical Expenses	**3,912,764,275**	**341,477,486**	**(1,637,188)**	**38,872,046**	**2,502,321**	**-**	**4,293,978,939**
Medical Loss Ratio	*92.7%*	*91.5%*	*0.0%*	*78.2%*	*96.3%*	*0.0%*	*92.5%*
GROSS MARGIN	**308,964,740**	**31,531,191**	**(1,560,177)**	**10,859,188**	**96,744**	**-**	**349,891,686**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	126,578,854	11,773,426		1,882,220	1,131,915		141,366,415
Non-Salary Operating Expenses	38,361,498	6,628,730		934,899	15,630	665,034	46,605,791
Depreciation & Amortization	8,690,126			10,711			8,700,837
Other Operating Expenses	30,998,830	932,002		100,027	84,862		32,115,721
Indirect Cost Allocation, Occupancy	(8,446,939)	12,105,474		192,953	80,944		3,932,431
Total Administrative Expenses	**196,182,370**	**31,439,631**	**-**	**3,120,809**	**1,313,351**	**665,034**	**232,721,195**
Administrative Loss Ratio	*4.6%*	*8.4%*	*0.0%*	*6.3%*	*50.5%*	*0.0%*	*5.0%*
Operating Income/(Loss)	**112,782,370**	**91,560**	**(1,560,177)**	**7,738,379**	**(1,216,607)**	**(665,034)**	**117,170,491**
Investments and Other Non-Operating	5,627,547						166,835,894
CHANGE IN NET ASSETS	**$ 118,409,918**	**$ 91,560**	**$ (1,560,177)**	**$ 7,738,379**	**$ (1,216,607)**	**$ (665,034)**	**$ 284,006,385**
BUDGETED CHANGE IN NET ASSETS	(225,881,958)	(11,696,869)	-	(926,509)	(1,247,297)	(4,583,330)	(185,168,949)
Variance to Budget - Fav/(Unfav)	$ 344,291,876	$ 11,788,429	$ (1,560,177)	$ 8,664,888	$ 30,690	$ 3,918,296	$ 469,175,334

Back to Agenda

CalOptima Health

Highlights – Consolidated, for Eleven Months Ending May 31, 2025

MONTH TO DATE RESULTS:

- Change in Net Assets is $4.4 million, favorable to budget $23.2 million
- Operating deficit is $2.1 million, with a surplus in non-operating income of $6.5 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $284.0 million, favorable to budget $469.2 million
- Operating surplus is $117.2 million, with a surplus in non-operating income of $166.8 million

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

May 2025				July 2024 - May 2025		
Actual	Budget	Variance	Operating Income (Loss)	Actual	Budget	Variance
(0.3)	(21.5)	21.2	Medi-Cal	112.8	(225.9)	338.7
(2.0)	(1.6)	(0.5)	OneCare	0.1	(11.7)	11.8
0.8	(0.1)	0.9	PACE	7.7	(0.9)	8.7
(0.1)	(0.1)	0.0	MSSP	(1.2)	(1.2)	0.0
0.0	0.0	0.0	OCC	(1.6)	0.0	(1.6)
(0.5)	(0.9)	0.5	Covered CA	(0.7)	(4.6)	3.9
(2.1)	**(24.2)**	**22.1**	**Total Operating Income (Loss)**	**117.2**	**(244.3)**	**361.5**
			Non-Operating Income (Loss)			
6.5	6.7	(0.1)	Net Investment Income/Expense	175.9	73.3	102.5
0.0	0.0	0.0	Other Income/Expense	0.0	0.0	0.0
6.5	**5.4**	**1.2**	**Total Non-Operating Income/(Loss)**	**166.8**	**59.2**	**107.7**
4.4	**(18.8)**	**23.2**	**TOTAL**	**284.0**	**(185.2)**	**469.2**

CalOptima Health - Consolidated
Enrollment Summary
For the Eleven Months Ending May 31, 2025

May 2025					July 2024 - May 2025			
Actual	**Budget**	**$ Variance**	**%Variance**	**Enrollment (by Aid Category)**	**Actual**	**Budget**	**$ Variance**	**%Variance**
151,247	139,052	12,195	8.8%	SPD	1,619,003	1,512,712	106,291	7.0%
260,096	272,043	(11,947)	(4.4%)	TANF Child	2,925,386	2,994,506	(69,120)	(2.3%)
129,052	138,555	(9,503)	(6.9%)	TANF Adult	1,436,884	1,519,224	(82,340)	(5.4%)
2,584	2,596	(12)	(0.5%)	LTC	27,487	28,632	(1,145)	(4.0%)
335,128	322,733	12,395	3.8%	MCE	3,712,736	3,553,571	159,165	4.5%
8,723	9,543	(820)	(8.6%)	WCM	104,034	105,082	(1,048)	(1.0%)
886,830	**884,522**	**2,308**	**0.3%**	**Medi-Cal Total**	**9,825,530**	**9,713,727**	**111,803**	**1.2%**
17,476	**17,537**	**(61)**	**(0.3%)**	**OneCare**	**189,692**	**191,822**	**(2,130)**	**(1.1%)**
516	**492**	**24**	**4.9%**	**PACE**	**5,551**	**5,281**	**270**	**5.1%**
544	**568**	**(24)**	**(4.2%)**	**MSSP**	**5,674**	**6,248**	**(574)**	**(9.2%)**
904,822	**902,551**	**2,271**	**0.3%**	**CalOptima Health Total**	**10,020,773**	**9,910,830**	**109,943**	**1.1%**
				Enrollment (by Network)				
347,114	302,760	44,354	14.6%	HMO	3,646,821	3,333,634	313,187	9.4%
167,770	178,839	(11,069)	(6.2%)	PHC	1,900,418	1,966,846	(66,428)	(3.4%)
68,119	132,589	(64,470)	(48.6%)	Shared Risk Group	1,048,512	1,462,300	(413,788)	(28.3%)
303,827	270,334	33,493	12.4%	Fee for Service	3,229,779	2,950,947	278,832	9.4%
886,830	**884,522**	**2,308**	**0.3%**	**Medi-Cal Total**	**9,825,530**	**9,713,727**	**111,803**	**1.2%**
17,476	**17,537**	**(61)**	**(0)**	**OneCare**	**189,692**	**191,822**	**(2,130)**	**(0)**
516	**492**	**24**	**4.9%**	**PACE**	**5,551**	**5,281**	**270**	**5.1%**
544	**568**	**(24)**	**(4.2%)**	**MSSP**	**5,674**	**6,248**	**(574)**	**(9.2%)**
904,822	**902,551**	**2,271**	**0.3%**	**CalOptima Health Total**	**10,020,773**	**9,910,830**	**109,943**	**1.1%**

Note: Total membership does not include MSSP

Back to Agenda

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2025

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD Actual	YTD Budget	Variance
HMOs															
SPD	17,150	16,511	16,610	16,774	20,293	20,211	20,247	20,491	20,500	20,675	20,674		210,136	180,933	29,203
TANF Child	66,405	65,921	65,198	64,503	77,875	77,766	77,607	76,962	75,128	74,225	73,953		795,543	759,828	35,715
TANF Adult	54,590	55,734	55,056	54,535	70,864	70,611	70,439	69,398	68,589	68,129	67,874		705,819	692,671	13,148
LTC	2				1		3	2					8		8
MCE	153,578	153,602	152,129	151,153	190,284	189,645	189,821	187,512	185,344	184,148	183,128		1,920,344	1,685,005	235,339
WCM	1,241	1,234	1,214	1,163	1,370	1,479	1,514	1,430	1,429	1,412	1,485		14,971	15,197	(226)
Total	292,966	293,002	290,207	288,128	360,687	359,712	359,631	355,795	350,990	348,589	347,114		3,646,821	3,333,634	**313,187**
PHCs															
SPD	4,906	4,644	4,820	4,796	4,736	4,780	4,737	4,799	4,812	4,820	4,970		52,820	49,619	3,201
TANF Child	140,053	138,903	137,874	136,823	136,101	135,163	133,694	132,827	131,272	130,720	130,991		1,484,421	1,552,818	(68,397)
TANF Adult	3,994	4,186	4,191	4,104	4,165	4,170	4,132	4,089	4,023	4,021	3,998		45,073	55,748	(10,675)
LTC													0		0
MCE	22,999	22,762	22,600	22,551	22,507	22,511	22,520	22,277	21,942	21,838	21,725		246,232	237,996	8,236
WCM	6,571	7,308	6,733	6,550	6,336	6,573	6,580	6,496	6,433	6,206	6,086		71,872	70,665	1,207
Total	178,523	177,803	176,218	174,824	173,845	173,197	171,663	170,488	168,482	167,605	167,770		1,900,418	1,966,846	**(66,428)**
Shared Risk Groups															
SPD	7,270	7,077	7,057	7,133	3,422	3,411	3,353	3,413	3,321	3,422	3,522		52,401	71,405	(19,004)
TANF Child	32,783	32,842	32,545	32,325	18,564	18,412	18,308	18,287	18,168	18,156	18,653		259,043	345,093	(86,050)
TANF Adult	27,519	29,041	28,870	28,586	11,818	11,756	11,734	11,438	11,353	11,227	11,540		194,882	319,328	(124,446)
LTC				1									1	11	(10)
MCE	74,704	74,918	74,517	74,138	34,102	34,260	34,467	34,469	34,145	33,995	34,311		538,026	718,344	(180,318)
WCM	702	701	716	707	91	362	367	254	149	17	93		4,159	8,119	(3,960)
Total	**142,978**	**144,579**	**143,705**	**142,890**	**67,997**	**68,201**	**68,229**	**67,861**	**67,136**	**66,817**	**68,119**		**1,048,512**	**1,462,300**	**(413,788)**
Fee for Service (Dual)															
SPD	100,293	99,792	100,297	100,986	101,924	102,883	104,042	104,622	105,388	106,033	107,813		1,134,073	1,047,319	86,754
TANF Child													0	13	(13)
TANF Adult	1,145	1,159	1,123	1,052	1,035	1,056	1,037	1,011	937	930	899		11,384	20,239	(8,855)
LTC	2,178	2,203	2,209	2,222	2,208	2,237	2,234	2,204	2,216	2,218	2,328		24,457	25,671	(1,214)
MCE	4,008	4,703	4,593	4,431	4,388	4,283	4,088	3,863	3,645	3,457	3,380		44,839	100,442	(55,603)
WCM	6	7	8	15	12	12	13	13	12	15	24		137	99	38
Total	**107,630**	**107,864**	**108,230**	**108,706**	**109,567**	**110,471**	**111,414**	**111,713**	**112,198**	**112,653**	**114,444**		**1,214,890**	**1,193,783**	**21,107**
Fee for Service (Non-Dual - Total)															
SPD	15,636	15,436	15,868	15,819	15,925	16,332	14,857	15,132	15,249	15,051	14,268		169,573	163,436	6,137
TANF Child	32,741	33,377	33,868	33,995	34,269	36,369	36,010	36,850	36,407	35,994	36,499		386,379	336,754	49,625
TANF Adult	40,618	42,145	42,625	42,860	43,229	44,456	44,366	45,308	44,776	44,602	44,741		479,726	431,238	48,488
LTC	278	254	271	278	285	295	270	289	262	283	256		3,021	2,950	71
MCE	80,536	82,491	83,546	83,778	84,679	89,895	89,750	92,778	91,844	91,414	92,584		963,295	811,784	151,511
WCM	1,205	1,184	1,178	1,114	1,177	1,198	1,369	1,246	1,143	1,046	1,035		12,895	11,002	1,893
Total	**171,014**	**174,887**	**177,356**	**177,844**	**179,564**	**188,545**	**186,622**	**191,603**	**189,681**	**188,390**	**189,383**		**2,014,889**	**1,757,164**	**257,725**
Grand Totals															
SPD	145,255	143,460	144,652	145,508	146,300	147,617	147,236	148,457	149,270	150,001	151,247		1,619,003	1,512,712	106,291
TANF Child	271,982	271,043	269,485	267,646	266,809	267,710	265,619	264,926	260,975	259,095	260,096		2,925,386	2,994,506	(69,120)
TANF Adult	127,866	132,265	131,865	131,137	131,111	132,049	131,708	131,244	129,678	128,909	129,052		1,436,884	1,519,224	(82,340)
LTC	2,458	2,457	2,480	2,501	2,494	2,532	2,507	2,495	2,478	2,501	2,584		27,487	28,632	(1,145)
MCE	335,825	338,476	337,385	336,051	335,960	340,594	340,646	340,899	336,920	334,852	335,128		3,712,736	3,553,571	159,165
WCM	9,725	10,434	9,849	9,549	8,986	9,624	9,843	9,439	9,166	8,696	8,723		104,034	105,082	(1,048)
Total MediCal MM	**893,111**	**898,135**	**895,716**	**892,392**	**891,660**	**900,126**	**897,559**	**897,460**	**888,487**	**884,054**	**886,830**		**9,825,530**	**9,713,727**	**111,803**
OneCare	**17,311**	**17,307**	**17,282**	**17,173**	**17,156**	**17,037**	**17,090**	**17,238**	**17,283**	**17,339**	**17,476**		**189,692**	**191,822**	**(2,130)**
PACE	**506**	**508**	**503**	**498**	**502**	**506**	**502**	**503**	**501**	**506**	**516**		**5,551**	**5,281**	**270**
MSSP	**473**	**480**	**487**	**506**	**524**	**519**	**533**	**538**	**532**	**538**	**544**		**5,674**	**6,248**	**(574)**
Covered CA	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**	**0**	**0**
Grand Total	**910,928**	**915,950**	**913,501**	**910,063**	**909,318**	**917,669**	**915,151**	**915,201**	**906,271**	**901,899**	**904,822**		**10,020,773**	**9,910,830**	**109,943**

Note:* Total membership does not include MSSP

Back to Agenda

ENROLLMENT– MAY MONTH:

Overall, May enrollment was 904,822

- Favorable to budget 2,271 or 0.3%
- Increased 2,923 or 0.3% from Prior Month (PM) (April 2025)
- Decreased 18,207 or 2.0% from Prior Year (PY) (May 2024)

Medi-Cal enrollment was 886,830

- Favorable to budget 2,308 or 0.3%
- Medi-Cal Expansion (MCE) favorable to budget 12,395
- Seniors and Persons with Disabilities (SPD) favorable to budget 12,195
- Temporary Assistance for Needy Families (TANF) unfavorable to budget 21,450
- Whole Child Model (WCM) unfavorable to budget 820
- Long-Term Care (LTC) unfavorable to budget 12
- Increased 2,776 or 0.3% from PM

OneCare enrollment was 17,476

- Unfavorable to budget 61 or 0.3%
- Increased 137 or 0.8% from PM

PACE enrollment was 516

- Favorable to budget 24 or 4.9%
- Increased 10 or 2.0% from PM

MSSP enrollment was 544

- Unfavorable to budget 24 or 4.2%
- Increased 6 or 1.1% from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2025

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
886,830	**884,522**	**2,308**	**0.3%**	**Member Months**	**9,825,530**	**9,713,727**	**111,803**	**1.2%**
				Revenues				
355,216,686	319,658,819	35,557,867	11.1%	Medi-Cal Capitation Revenue	4,221,729,015	3,494,906,566	726,822,449	20.8%
355,216,686	**319,658,819**	**35,557,867**	**11.1%**	**Total Operating Revenue**	**4,221,729,015**	**3,494,906,566**	**726,822,449**	**20.8%**
				Medical Expenses				
115,343,244	111,475,215	(3,868,029)	(3.5%)	Provider Capitation	1,254,346,788	1,226,984,192	(27,362,596)	(2.2%)
72,884,374	67,535,502	(5,348,872)	(7.9%)	Facilities Claims	716,503,012	717,779,019	1,276,007	0.2%
70,916,723	68,277,526	(2,639,197)	(3.9%)	Professional Claims	736,066,590	746,472,916	10,406,326	1.4%
55,797,519	50,724,775	(5,072,744)	(10.0%)	MLTSS	542,795,927	537,973,895	(4,822,032)	(0.9%)
10,687,624	10,162,350	(525,274)	(5.2%)	Incentive Payments	128,335,019	141,816,722	13,481,703	9.5%
9,009,167	9,795,501	786,334	8.0%	Medical Management	93,312,281	101,108,894	7,796,613	7.7%
1,562,131	1,830,207	268,076	14.6%	Other Medical Expenses	441,404,658	20,132,289	(421,272,369)	(2,092.5%)
336,200,783	**319,801,076**	**(16,399,707)**	**(5.1%)**	**Total Medical Expenses**	**3,912,764,275**	**3,492,267,927**	**(420,496,348)**	**(12.0%)**
19,015,903	**(142,257)**	**19,158,160**	**13,467.3%**	**Gross Margin**	**308,964,740**	**2,638,639**	**306,326,101**	**11,609.2%**
				Administrative Expenses				
12,074,631	12,372,598	297,967	2.4%	Salaries, Wages & Employee Benefits	126,578,854	132,277,307	5,698,453	4.3%
954,147	1,862,287	908,140	48.8%	Professional Fees	13,375,802	17,399,085	4,023,282	23.1%
1,955,561	2,587,696	632,135	24.4%	Purchased Services	20,956,641	27,196,786	6,240,145	22.9%
294,597	481,815	187,218	38.9%	Printing & Postage	4,029,055	5,770,152	1,741,097	30.2%
1,521,271	1,026,358	(494,913)	(48.2%)	Depreciation & Amortization	8,690,126	11,289,938	2,599,812	23.0%
3,235,719	3,616,175	380,456	10.5%	Other Operating Expenses	30,998,830	41,258,071	10,259,240	24.9%
(707,670)	(606,431)	101,239	16.7%	Indirect Cost Allocation, Occupancy	(8,446,939)	(6,670,741)	1,776,198	26.6%
19,328,257	**21,340,498**	**2,012,241**	**9.4%**	**Total Administrative Expenses**	**196,182,370**	**228,520,597**	**32,338,227**	**14.2%**
				Non-Operating Income (Loss)				
49,764	-	49,764	100.0%	Net Operating Tax	5,633,875	-	5,633,875	100.0%
(8,537)	-	(8,537)	(100.0%)	Other Income/Expense	(6,328)	-	(6,328)	(100.0%)
41,227	**-**	**41,227**	**100.0%**	**Total Non-Operating Income (Loss)**	**5,627,547**	**-**	**5,627,547**	**100.0%**
(271,127)	**(21,482,755)**	**21,211,628**	**98.7%**	**Change in Net Assets**	**118,409,918**	**(225,881,958)**	**344,291,876**	**152.4%**
94.6%	***100.0%***	***(5.4%)***		***Medical Loss Ratio***	***92.7%***	***99.9%***	***(7.2%)***	
5.4%	***6.7%***	***1.2%***		***Admin Loss Ratio***	***4.6%***	***6.5%***	***1.9%***	

MEDI-CAL INCOME STATEMENT– MAY MONTH:

REVENUES are $355.2 million, favorable to budget $35.6 million:

- Favorable volume variance of $0.8 million
- Favorable price related variance of $34.7 million
  - $35.8 million due to favorable member mix and draft Calendar Year (CY) 2025 capitation rates from the Department of Health Care Services (DHCS)
  - Offset by:
    - $2.5 million from Proposition 56, Enhanced Care Management (ECM) and Unsatisfactory Immigration Status (UIS) risk corridors

MEDICAL EXPENSES are $336.2 million, unfavorable to budget $16.4 million:

- Unfavorable volume variance of $0.8 million
- Unfavorable price related variance of $15.6 million:
  - Facilities Claims expense unfavorable variance of $5.2 million due to increase in utilization
  - Managed Long-Term Services and Supports (MLTSS) expense unfavorable variance of $4.9 million due to retroactive increase in LTC rates for CY 2024
  - Provider Capitation expense unfavorable variance of $3.6 million
  - Professional Claims expense unfavorable variance of $2.5 million

ADMINISTRATIVE EXPENSES are $19.3 million, favorable to budget $2.0 million:

- Non-Salary expense favorable to budget $1.7 million
- Salaries, Wages & Employee Benefits expense favorable to budget $0.3 million

CHANGE IN NET ASSETS is ($0.2) million, favorable to budget $21.2 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
17,476	**17,537**	**(61)**	**(0.3%)**	**Member Months**	**189,692**	**191,822**	**(2,130)**	**(1.1%)**
				Revenues				
10,422,307	26,573,259	(16,150,952)	(60.8%)	Medicare Part C Revenue	263,124,329	286,828,060	(23,703,731)	(8.3%)
12,720,637	9,529,512	3,191,125	33.5%	Medicare Part D Revenue	109,884,348	103,787,492	6,096,856	5.9%
23,142,943	**36,102,771**	**(12,959,828)**	**(35.9%)**	**Total Operating Revenue**	**373,008,676**	**390,615,552**	**(17,606,876)**	**(4.5%)**
				Medical Expenses				
6,190,005	16,220,479	10,030,474	61.8%	Provider Capitation	154,536,635	175,124,289	20,587,654	11.8%
4,295,366	5,132,239	836,873	16.3%	Inpatient	46,307,318	53,750,712	7,443,394	13.8%
2,029,107	1,794,157	(234,950)	(13.1%)	Ancillary	21,299,203	19,107,399	(2,191,804)	(11.5%)
8,146,505	9,333,069	1,186,564	12.7%	Prescription Drugs	99,430,282	98,273,194	(1,157,088)	(1.2%)
137,249	442,625	305,376	69.0%	Incentive Payments	6,515,656	5,389,670	(1,125,986)	(20.9%)
1,031,381	1,450,178	418,797	28.9%	Medical Management	11,056,656	15,269,787	4,213,131	27.6%
392,878	-	(392,878)	(100.0%)	Other Medical Expenses	2,331,736	-	(2,331,736)	(100.0%)
22,222,492	**34,372,747**	**12,150,255**	**35.3%**	**Total Medical Expenses**	**341,477,486**	**366,915,051**	**25,437,565**	**6.9%**
920,451	**1,730,024**	**(809,573)**	**(46.8%)**	**Gross Margin**	**31,531,191**	**23,700,501**	**7,830,690**	**33.0%**
				Administrative Expenses				
1,020,699	1,253,451	232,752	18.6%	Salaries, Wages & Employee Benefits	11,773,426	13,333,570	1,560,144	11.7%
82,492	142,033	59,541	41.9%	Professional Fees	962,341	1,379,713	417,372	30.3%
527,124	571,960	44,836	7.8%	Purchased Services	4,185,252	5,575,380	1,390,128	24.9%
213,213	164,950	(48,263)	(29.3%)	Printing & Postage	1,481,136	2,483,450	1,002,314	40.4%
73,946	121,954	48,008	39.4%	Other Operating Expenses	932,002	1,338,344	406,342	30.4%
1,036,392	1,026,083	(10,309)	(1.0%)	Indirect Cost Allocation, Occupancy	12,105,474	11,286,913	(818,561)	(7.3%)
2,953,866	**3,280,431**	**326,565**	**10.0%**	**Total Administrative Expenses**	**31,439,631**	**35,397,370**	**3,957,739**	**11.2%**
(2,033,415)	**(1,550,407)**	**(483,008)**	**(31.2%)**	**Change in Net Assets**	**91,560**	**(11,696,869)**	**11,788,429**	**100.8%**
96.0%	***95.2%***	***0.8%***		***Medical Loss Ratio***	***91.5%***	***93.9%***	***(2.4%)***	
12.8%	***9.1%***	***(3.7%)***		***Admin Loss Ratio***	***8.4%***	***9.1%***	***0.6%***	

Back to Agenda

ONECARE INCOME STATEMENT– MAY MONTH:

REVENUES are $23.1 million, unfavorable to budget $13.0 million:

- Unfavorable volume related variance of $0.1 million
- Unfavorable price related variance of $12.8 million due to less risk adjustable data for CY 2024 Hierarchical Condition Category (HCC) estimates compared to prior year

MEDICAL EXPENSES are $22.2 million, favorable to budget $12.2 million:

- Favorable volume related variance of $0.1 million
- Favorable price related variance of $12.0 million
  - Provider Capitation expense favorable variance of $10.0 million primarily due to CY 2024 HCC
  - Prescription Drugs expense favorable variance of $1.2 million

ADMINISTRATIVE EXPENSES are $3.0 million, favorable to budget $0.3 million

- Salaries, Wages & Employee Benefits expense favorable to budget $0.2 million
- Non-Salary expense favorable to budget $0.1 million

CHANGE IN NET ASSETS is ($2.0) million, unfavorable to budget $0.5 million

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
516	**492**	**24**	**4.9%**	**Member Months**	**5,551**	**5,281**	**270**	**5.1%**
				Revenues				
3,520,559	3,090,252	430,307	13.9%	Medi-Cal Capitation Revenue	36,754,761	33,160,511	3,594,250	10.8%
1,143,308	786,824	356,484	45.3%	Medicare Part C Revenue	9,353,825	8,248,044	1,105,781	13.4%
426,381	248,742	177,639	71.4%	Medicare Part D Revenue	3,622,648	2,660,114	962,534	36.2%
5,090,247	**4,125,818**	**964,429**	**23.4%**	**Total Operating Revenue**	**49,731,234**	**44,068,669**	**5,662,565**	**12.8%**
				Medical Expenses				
1,321,459	1,385,994	64,535	4.7%	Medical Management	14,023,068	15,040,209	1,017,141	6.8%
928,965	789,462	(139,503)	(17.7%)	Facilities Claims	7,762,352	8,246,236	483,884	5.9%
855,896	874,161	18,265	2.1%	Professional Claims	7,741,795	9,110,724	1,368,929	15.0%
561,367	591,850	30,483	5.2%	Prescription Drugs	6,432,704	6,098,066	(334,638)	(5.5%)
21,967	48,551	26,584	54.8%	MLTSS	216,193	364,106	147,913	40.6%
291,724	260,446	(31,278)	(12.0%)	Patient Transportation	2,695,934	2,864,915	168,981	5.9%
3,981,378	**3,950,464**	**(30,914)**	**(0.8%)**	**Total Medical Expenses**	**38,872,046**	**41,724,256**	**2,852,210**	**6.8%**
1,108,870	**175,354**	**933,516**	**532.4%**	**Gross Margin**	**10,859,188**	**2,344,413**	**8,514,775**	**363.2%**
				Administrative Expenses				
184,441	179,017	(5,424)	(3.0%)	Salaries, Wages & Employee Benefits	1,882,220	1,903,680	21,460	1.1%
20,417	8,708	(11,709)	(134.5%)	Professional Fees	80,177	96,088	15,911	16.6%
105,522	72,474	(33,048)	(45.6%)	Purchased Services	718,452	741,627	23,175	3.1%
1,668	10,530	8,862	84.2%	Printing & Postage	136,269	181,920	45,651	25.1%
991	1,600	609	38.1%	Depreciation & Amortization	10,711	17,600	6,889	39.1%
7,080	14,252	7,172	50.3%	Other Operating Expenses	100,027	145,969	45,942	31.5%
16,899	17,008	109	0.6%	Indirect Cost Allocation, Occupancy	192,953	184,038	(8,915)	(4.8%)
337,017	**303,589**	**(33,428)**	**(11.0%)**	**Total Administrative Expenses**	**3,120,809**	**3,270,922**	**150,113**	**4.6%**
771,852	**(128,235)**	**900,087**	**701.9%**	**Change in Net Assets**	**7,738,379**	**(926,509)**	**8,664,888**	**935.2%**
78.2%	***95.7%***	***(17.5%)***		***Medical Loss Ratio***	***78.2%***	***94.7%***	***(16.5%)***	
6.6%	***7.4%***	***0.7%***		***Admin Loss Ratio***	***6.3%***	***7.4%***	***1.1%***	

Back to Agenda

CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
544	**568**	**(24)**	**(4.2%)**	**Member Months**	**5,674**	**6,248**	**(574)**	**(9.2%)**
				Revenues				
255,790	253,517	2,273	0.9%	Revenue	2,599,065	2,788,687	(189,622)	(6.8%)
255,790	**253,517**	**2,273**	**0.9%**	**Total Operating Revenue**	**2,599,065**	**2,788,687**	**(189,622)**	**(6.8%)**
				Medical Expenses				
193,632	207,784	14,152	6.8%	Medical Management	2,068,976	2,285,624	216,648	9.5%
49,875	32,957	(16,918)	(51.3%)	Waiver Services	433,345	362,527	(70,818)	(19.5%)
193,632	207,784	14,152	6.8%	Total Medical Management	2,068,976	2,285,624	216,648	9.5%
49,875	32,957	(16,918)	(51.3%)	Total Waiver Services	433,345	362,527	(70,818)	(19.5%)
243,508	**240,741**	**(2,767)**	**(1.1%)**	**Total Program Expenses**	**2,502,321**	**2,648,151**	**145,830**	**5.5%**
12,282	**12,776**	**(494)**	**(3.9%)**	**Gross Margin**	**96,744**	**140,536**	**(43,792)**	**(31.2%)**
				Administrative Expenses				
104,739	112,799	8,060	7.1%	Salaries, Wages & Employee Benefits	1,131,915	1,200,833	68,918	5.7%
1,417	1,417	0	0.0%	Professional Fees	15,583	15,587	4	0.0%
5	-	(5)	(100.0%)	Purchased Services	47	-	(47)	(100.0%)
6,910	8,250	1,340	16.2%	Other Operating Expenses	84,862	90,750	5,888	6.5%
6,804	7,333	529	7.2%	Indirect Cost Allocation, Occupancy	80,944	80,663	(281)	(0.3%)
119,875	**129,799**	**9,924**	**7.6%**	**Total Administrative Expenses**	**1,313,351**	**1,387,833**	**74,482**	**5.4%**
(107,593)	**(117,023)**	**9,430**	**8.1%**	**Change in Net Assets**	**(1,216,607)**	**(1,247,297)**	**30,690**	**2.5%**
95.2%	***95.0%***	***0.2%***		***Medical Loss Ratio***	***96.3%***	***95.0%***	***1.3%***	
46.9%	***51.2%***	***4.3%***		***Admin Loss Ratio***	***50.5%***	***49.8%***	***(0.8%)***	

Back to Agenda

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Eleven Months Ending May 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
-	**-**	**-**	**0.0%**	**Member Months**	**-**	**-**	**-**	**0.0%**
				Revenues				
-	-	-	0.0%	Medicare Part C Revenue	(3,197,365)	-	(3,197,365)	(100.0%)
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**(3,197,365)**	**-**	**(3,197,365)**	**(100.0%)**
				Medical Expenses				
-	-	-	0.0%	Provider Capitation	(1,453,037)	-	1,453,037	100.0%
-	-	-	0.0%	Facilities Claims	(184,151)	-	184,151	100.0%
-	**-**	**-**	**0.0%**	**Total Medical Expenses**	**(1,637,188)**	**-**	**1,637,188**	**100.0%**
-	**-**	**-**	**0.0%**	**Gross Margin**	**(1,560,177)**	**-**	**(1,560,177)**	**(100.0%)**
				Administrative Expenses				
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**(1,560,177)**	**-**	**(1,560,177)**	**(100.0%)**
0.0%	***0.0%***	***0.0%***		***Medical Loss Ratio***	***51.2%***	***0.0%***	***51.2%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	

CalOptima Health
Covered CA
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
-	-	-	**0.0%**	**Member Months**	-	-	-	**0.0%**
				Revenues				
-	-	-	0.0%	Medi-Cal Capitation Revenue	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Medical Expenses				
-	-	-	**0.0%**	**Total Medical Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Gross Margin**	-	-	-	**0.0%**
				Administrative Expenses				
457,315	916,666	459,351	50.1%	Professional Fees	665,034	4,583,330	3,918,296	85.5%
457,315	**916,666**	**459,351**	**50.1%**	**Total Administrative Expenses**	**665,034**	**4,583,330**	**3,918,296**	**85.5%**
				Non-Operating Income (Loss)				
-	-	-	0.0%	Net Operating Tax	-	-	-	0.0%
-	-	-	0.0%	Net QAF & IGT Income/Expense	-	-	-	0.0%
-	-	-	0.0%	Other Income/Expense	-	-	-	0.0%
-	-	-	**0.0%**	**Total Non-Operating Income (Loss)**	-	-	-	**0.0%**
(457,315)	**(916,666)**	**459,351**	**50.1%**	**Change in Net Assets**	**(665,034)**	**(4,583,330)**	**3,918,296**	**85.5%**
0.0%	***0.0%***	***0.0%***		***Medical Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	

Back to Agenda

CalOptima Health
Building - 505 City Parkway
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
57,786	22,905	(34,881)	(152.3%)	Purchased Services	580,294	251,955	(328,339)	(130.3%)
181,376	195,000	13,624	7.0%	Depreciation & Amortization	1,990,944	2,145,000	154,056	7.2%
23,371	26,654	3,283	12.3%	Insurance Expense	269,529	293,194	23,665	8.1%
130,790	181,186	50,396	27.8%	Repair & Maintenance	1,344,576	1,993,046	648,470	32.5%
42,625	56,824	14,199	25.0%	Other Operating Expenses	615,377	625,064	9,687	1.5%
(435,949)	(482,569)	(46,620)	(9.7%)	Indirect Cost Allocation, Occupancy	(4,800,721)	(5,308,259)	(507,538)	(9.6%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

CalOptima Health
Building - 500 City Parkway
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
156,423	135,866	20,557	15.1%	Rental Income	1,774,081	1,494,526	279,555	18.7%
156,423	**135,866**	**20,557**	**15.1%**	**Total Operating Revenue**	**1,774,081**	**1,494,526**	**279,555**	**18.7%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
42,236	9,330	(32,906)	(352.7%)	Purchased Services	452,099	102,630	(349,469)	(340.5%)
58,789	51,000	(7,789)	(15.3%)	Depreciation & Amortization	609,340	561,000	(48,340)	(8.6%)
8,600	8,746	146	1.7%	Insurance Expense	91,500	96,206	4,706	4.9%
45,527	94,592	49,065	51.9%	Repair & Maintenance	485,104	1,040,512	555,408	53.4%
13,211	25,978	12,767	49.1%	Other Operating Expenses	250,803	285,758	34,955	12.2%
(17,830)	-	17,830	100.0%	Indirect Cost Allocation, Occupancy	(200,032)	-	200,032	100.0%
150,533	**189,646**	**39,113**	**20.6%**	**Total Administrative Expenses**	**1,688,814**	**2,086,106**	**397,292**	**19.0%**
5,890	**(53,780)**	**59,670**	**111.0%**	**Change in Net Assets**	**85,267**	**(591,580)**	**676,847**	**114.4%**

Back to Agenda

CalOptima Health
Building - 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
27,594	42,500	14,906	35.1%	Purchased Services	329,833	467,500	137,667	29.4%
9,397	21,000	11,603	55.3%	Depreciation & Amortization	103,372	231,000	127,628	55.3%
4,751	-	(4,751)	(100.0%)	Insurance Expense	51,250	-	(51,250)	(100.0%)
2,498	-	(2,498)	(100.0%)	Repair & Maintenance	5,271	-	(5,271)	(100.0%)
991	-	(991)	(100.0%)	Other Operating Expenses	12,025	-	(12,025)	(100.0%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
45,232	**63,500**	**18,268**	**28.8%**	**Total Administrative Expenses**	**501,750**	**698,500**	**196,750**	**28.2%**
(45,232)	**(63,500)**	**18,268**	**28.8%**	**Change in Net Assets**	**(501,750)**	**(698,500)**	**196,750**	**28.2%**

OTHER PROGRAM INCOME STATEMENTS – MAY MONTH:

PACE

- **CHANGE IN NET ASSETS** is $0.8 million, favorable to budget $0.9 million

MSSP

- **CHANGE IN NET ASSETS** is ($107,593), favorable to budget $9,430

Covered CA

- **CHANGE IN NET ASSETS** is ($0.5) million, favorable to budget $0.5 million

NON-OPERATING INCOME STATEMENTS – MAY MONTH:

BUILDING 500 City Parkway

- **CHANGE IN NET ASSETS** is $5,890, favorable to budget $59,670
  - Net of $156,423 in rental income and $150,533 in expenses

BUILDING 7900 Garden Grove Blvd

- **CHANGE IN NET ASSETS** is ($45,232), favorable to budget $18,268

INVESTMENT INCOME

- Unfavorable variance of $0.1 million compared to budget. Overall income of $6.1 million due to $13.3 million of interest income and $7.6 million of realized and unrealized loss on investments

CalOptima Health
Balance Sheet
May 31, 2025

	May-25	April-25	$ Change	% Change
ASSETS				
Current Assets				
Cash and Cash Equivalents	585,417,907	647,124,850	(61,706,943)	(9.5%)
Short-term Investments	1,306,481,200	1,310,577,272	(4,096,072)	(0.3%)
Capitation Receivable	595,472,115	537,951,695	57,520,419	10.7%
Receivables - Other	93,591,246	87,624,913	5,966,333	6.8%
Prepaid Expenses	14,208,216	13,488,139	720,078	5.3%
Total Current Assets	**2,595,170,684**	**2,596,766,869**	**(1,596,185)**	**(0.1%)**
Board Designated Assets				
Board Designated Reserves	1,573,812,290	1,574,463,632	(651,342)	(0.0%)
Statutory Designated Reserves	131,292,301	131,577,245	(284,944)	(0.2%)
Total Designated Assets	**1,705,104,591**	**1,706,040,877**	**(936,286)**	**(0.1%)**
Restricted Deposit	**300,000**	**300,000**	**-**	**0.0%**
Capital Assets, Net	**98,528,317**	**100,263,668**	**(1,735,351)**	**(1.7%)**
Total Assets	**4,399,103,592**	**4,403,371,414**	**(4,267,822)**	**(0.1%)**
Deferred Outflows of Resources				
Advance Discretionary Payment	49,999,717	49,999,717	-	0.0%
Net Pension	24,549,290	24,549,290	-	0.0%
Other Postemployment Benefits	1,350,000	1,350,000	-	0.0%
Total Deferred Outflows of Resources	**75,899,007**	**75,899,007**	**-**	**0.0%**
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	**4,475,002,599**	**4,479,270,421**	**(4,267,822)**	**(0.1%)**
LIABILITIES				
Current Liabilities				
Accounts Payable	169,146,029	105,118,422	64,027,606	60.9%
Medical Claims Liability	1,118,595,383	1,221,299,157	(102,703,774)	(8.4%)
Accrued Payroll Liabilities	20,192,220	25,847,041	(5,654,822)	(21.9%)
Deferred Revenue	52,706,769	14,468,620	38,238,149	264.3%
Other Current Liabilities	-	-	-	0.0%
Capitation & Withholds	147,550,408	150,387,620	(2,837,212)	(1.9%)
Total Current Liabilities	**1,508,190,809**	**1,517,120,861**	**(8,930,052)**	**(0.6%)**
GASB 96 Subscription Liabilities	17,058,702	17,058,702	-	0.0%
Community Reinvestment	148,058,180	147,803,571	254,610	0.2%
Capital Lease Payable	249,289	258,865	(9,576)	(3.7%)
Postemployment Health Care Plan	17,729,256	17,697,644	31,612	0.2%
Net Pension Liability	45,981,359	45,981,359	-	0.0%
Total Liabilities	**1,737,267,595**	**1,745,921,002**	**(8,653,407)**	**(0.5%)**
Deferred Inflows of Resources				
Net Pension	2,248,445	2,248,445	-	0.0%
Other Postemployment Benefits	6,398,000	6,398,000	-	0.0%
Total Deferred Inflows of Resources	**8,646,445**	**8,646,445**	**-**	**0.0%**
Net Position				
Required TNE	129,014,190	128,094,238	919,953	0.7%
Funds in excess of TNE	2,600,074,369	2,596,608,736	3,465,632	0.1%
Total Net Position	**2,729,088,559**	**2,724,702,974**	**4,385,585**	**0.2%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION	**4,475,002,599**	**4,479,270,421**	**(4,267,822)**	**(0.1%)**

Back to Agenda

BALANCE SHEET – MAY MONTH:

ASSETS of $4.5 billion decreased $4.3 million from April or 0.1%

- Operating Cash and Short-term Investments decreased $65.8 million due to provider payments of $106.6 million for the Hospital Quality Assurance Fee (HQAF) program, offset by increases of $36.9 million for the June Centers for Medicare and Medicaid Services (CMS) OneCare (OC) capitation received in advance and current month investment income
- Capitation Receivables increased $57.5 million primarily due to one month of Managed Care Organization (MCO) tax revenue due from DHCS
- Receivable – Other increased $6.0 million primarily due to Part D receivables

LIABILITIES of $1.7 billion decreased $8.7 million from April or 0.5%

- Medical Claims Liability decreased $102.7 million due to the payout of $106.6 million of HQAF directed payments, offset by current month Incurred But Not Received (IBNR) accrual activity.
- Accrued Payroll Liabilities decreased $5.7 million due to the variability in the number of days in the month and the pay period timing
- Accounts Payable increased $64.0 million primarily due to the MCO tax payment
- Deferred Revenue increased $38.2 million due to the June OC CMS capitation received in advance.

NET ASSETS of $2.7 billion, increased $4.4 million from April or 0.2%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of May 31, 2025

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	786,976,185				
MetLife Tier One	786,836,105				
Board Designated Reserves	1,573,812,290	1,018,934,643	1,630,295,429	554,877,647	(56,483,139)
Current Reserve Level (X months of average monthly revenue) [1]	*3.86*	*2.50*	*4.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	65,769,930				
MetLife Tier Two	65,522,371				
Statutory Designated Reserves	131,292,301	129,014,190	141,915,610	2,278,111	(10,623,308)
Current Reserve Level (X min. TNE) [1]	*1.02*	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

CalOptima Health
Statement of Cash Flow
May 31, 2025

	May 2025	July 2024 - May 2025
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	4,385,585	284,006,385
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation & Amortization	1,771,824	11,404,491
Changes in assets and liabilities:		
Prepaid expenses and other	(720,078)	(3,039,097)
Capitation receivable	(63,486,752)	(134,376,877)
Medical claims liability	(102,703,774)	(33,248,742)
Deferred revenue	38,238,149	37,445,606
Payable to health networks	(2,837,212)	(28,683,286)
Accounts payable	64,027,606	(3,173,578)
Accrued payroll	(5,623,210)	(5,335,193)
Other accrued liabilities	245,033	41,717,294
Net cash provided by/(used in) operating activities	(66,702,828)	166,717,004
GASB 68, GASB 75 and Advance Discretionary Payment 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	4,096,072	471,414,740
Change in Property and Equipment	(36,473)	(13,372,001)
Change in Restricted Deposit & Other	-	-
Change in Board Designated Reserve	936,286	(567,341,153)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	4,995,885	(109,298,414)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	(61,706,943)	57,418,590
CASH AND CASH EQUIVALENTS, beginning of period	647,124,850	527,999,317
CASH AND CASH EQUIVALENTS, end of period	**585,417,907**	**585,417,907**

Back to Agenda

CalOptima Health
Spending Plan
For the Eleven Months Ending May 31, 2025

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @5/31/2025	**$2,729.1**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,573.8**			**57.7%**
	Statutory Designated Reserve[1]	**$131.3**			**4.8%**
	Capital Assets, net of Depreciation	**$98.5**			**3.6%**
Resources Allocated[3]	Homeless Health Initiative[2]	$18.6	$66.0	$47.4	0.7%
	Housing and Homelessness Incentive Program[2]	21.9	87.4	65.5	0.8%
	Intergovernmental Transfers (IGT)[4]	54.1	111.7	57.6	2.0%
	Digital Transformation and Workplace Modernization[3]	33.5	100.0	66.5	1.2%
	CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
	CalFresh and Redetermination Outreach Strategy	1.8	6.0	4.2	0.1%
	Coalition of Orange County Community Health Centers Grant	20.0	50.0	30.0	0.7%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives[4]	0.2	0.5	0.3	0.0%
	General Awareness Campaign	0.9	4.7	3.8	0.0%
	Member Health Needs Assessment	0.9	1.3	0.4	0.0%
	Five-Year Hospital Quality Program Beginning MY 2022	121.7	153.5	31.8	4.5%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.4%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program Grant	3.5	5.0	1.5	0.1%
	Community Living and PACE center (previously approved for project located in Tustin)[4]	17.2	18.0	0.8	0.6%
	Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program Grant	1.5	2.7	1.2	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	44.5	50.0	5.5	1.6%
	Distribution Event - Naloxone Grant	2.2	15.0	12.8	0.1%
	Garden Grove Bldg. Improvement	10.0	10.5	0.5	0.4%
	Post-Pandemic Supplemental[4]	6.0	107.5	101.5	0.2%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.4%
	Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
	Outreach Strategy for newly eligible Adult Expansion members	3.4	7.6	4.2	0.1%
	Quality Initiatives from unearned Pay for Value Program	18.8	23.3	4.5	0.7%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.3	1.2	0.9	0.0%
	Medi-Cal Provider Rate Increases	333.3	526.2	192.9	12.2%
	Homeless Prevention and Stabilization Pilot Program	0.3	0.3	0.0	0.0%
	OneCare Member Engagement and Education	0.3	0.3	0.0	0.0%
	Subtotal:	**$765.8**	**$1,422.5**	**$656.7**	**28.1%**
Resources Available for Ne	Unallocated/Unassigned[1]	**$159.6**			**5.8%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 160 days of CalOptima Health's current operations.

[2] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.

[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

[4] On June 5, 2025, the Board of Directors approved the close out of Board-approved initiatives and transfer of remaining funds back to unallocated reserves.

CalOptima Health
Key Financial Indicators
As of May 31, 2025

	Item Name	May 2025				July 2024 - May 2025			
		Actual	Budget	Variance	%	Actual	Budget	Variance	%
Income Statement	Member Months	904,822	902,551	2,271	0.3%	10,020,773	9,910,830	109,943	1.1%
	Operating Revenue	383,705,667	360,140,925	23,564,742	6.5%	4,643,870,625	3,932,379,474	711,491,151	18.1%
	Medical Expenses	362,648,160	358,365,028	(4,283,132)	(1.2%)	4,293,978,939	3,903,555,385	(390,423,554)	(10.0%)
	General and Administrative Expense	23,196,331	25,970,983	2,774,652	10.7%	232,721,195	273,160,052	40,438,857	14.8%
	Non-Operating Income/(Loss)	6,524,410	5,370,555	1,153,855	21.5%	166,835,894	59,167,014	107,668,880	182.0%
	Summary of Income & Expenses	4,385,585	(18,824,531)	23,210,116	123.3%	284,006,384	(185,168,949)	469,175,333	253.4%
Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance		Actual	Budget	Variance	
	Consolidated	94.5%	99.5%	(5.0%)		92.5%	99.3%	(6.8%)	
	Administrative Loss Ratio (ALR)	Actual	Budget	Variance		Actual	Budget	Variance	
	Consolidated	6.0%	7.2%	1.2%		5.0%	6.9%	1.9%	

Key:

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

Investment	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
	@5/31/2025	2,985,456,521	2,916,063,487	69,393,034	2.4%
	Unallocated/Unassigned Reserve Balance	Current Month @ May 2025	Fiscal Year Ending June 2024	Change	%
	Consolidated	159,648,298	187,643,914	(27,995,616)	(14.9%)
	*Days Cash On Hand**	-			

*Total Designated Reserves and unallocated reserve amount can support approximately 160 days of CalOptima Health's current operations.

Back to Agenda

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Eleven Months Ending May 31, 2025

	May 2025				July 2024 - May 2025				All Time to Date			
	Actual Spend	Approved Budget	Variance $	Variance %	Actual Spend	Approved Budget	Variance $	Variance %	Actual Spend	Approved Budget	Variance $	Variance %
Capital Assets (Cost, Information Only):												
Total Capital Assets	**255,235**	**1,091,246**	**836,011**	**76.6%**	**6,358,387**	**5,885,720**	**(472,667)**	**(8.0%)**	**14,801,247**	**29,949,429**	**15,148,182**	**50.6%**
Operating Expenses:												
Salaries, Wages & Benefits	552,271	589,848	37,577	6.4%	6,242,282	6,488,328	246,046	3.8%	17,248,549	17,494,595	246,046	1.4%
Professional Fees	348,970	543,986	195,016	35.8%	3,976,830	5,868,514	1,891,684	32.2%	5,737,893	7,629,577	1,891,684	24.8%
Purchased Services	95,368	142,000	46,633	32.8%	909,704	1,562,000	652,296	41.8%	1,059,704	1,712,000	652,296	38.1%
GASB 96 Amortization Expenses	51,082	293,417	242,335	82.6%	540,884	3,227,587	2,686,703	83.2%	2,512,087	5,198,790	2,686,703	51.7%
Other Expenses	604,937	726,777	121,840	16.8%	6,332,723	8,109,879	1,777,156	21.9%	19,862,215	21,639,371	1,777,156	8.2%
Medical Management	229,256	-	(229,256)	0.0%	2,521,821	-	(2,521,821)	0.0%	5,272,899	2,751,078	(2,521,821)	(91.7%)
Total Operating Expenses	**1,881,884**	**2,296,028**	**414,144**	**18.0%**	**20,524,243**	**25,256,308**	**4,732,065**	**18.7%**	**51,693,347**	**56,425,411**	**4,732,065**	**8.4%**

Funding Balance Tracking:	**Approved Budget**	**Actual Spend**	**Variance**
Beginning Funding Balance	100,000,000	100,000,000	-
Less:			
Capital Assets[1]	31,525,709	14,801,247	16,724,462
FY2023 Operating Budget[2]	8,381,011	8,381,011	-
FY2024 Operating Budget	22,788,092	22,788,092	-
FY2025 Operating Budget	27,552,335	20,524,243	7,028,092
Ending Funding Balance	**9,752,853**	**33,505,406**	**23,752,553**
Add: Prior year unspent Operating Budget	-		
Total Available Funding	**9,752,853**		

[1] Staff will continue to monitor the project status of DTS' Capital Assets.
[2] Unspent budget from this period is added back to available DTS funding.
[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

Note: Report includes applicable transactions for GASB 96, Subscriptions - Based Information Technology Arrangements.

CalOptima Health
Summary of Homeless Health Initiatives (HHI) and Allocated Funds
As of May 31, 2025

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Days, HCAP and FQHC Administrative Support	963,261	913,595	49,666
FQHC (Community Health Center) Expansion	21,902	21,902	-
Homeless Clinical Access Program (HCAP) and CalOptima Days	9,888,914	4,334,952	5,553,962
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine	14,376,652	7,396,757	6,979,895
Outreach and Engagement	7,000,000	1,138,008	5,861,992
Housing and Homelessness Incentive Program (HHIP)*	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 106,100,000**	**$ 47,442,264**	**$ 58,657,736**
Transfer of funds to HHIP*	(40,100,000)	-	(40,100,000)
Program Total	**$ 66,000,000**	**$ 47,442,264**	**$ 18,557,736**

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

*On March 19, 2025, CalOptima Health's Board of Directors approved $9.3 million to expand the Street Medicine Program - $3.2 million remaining from Street Medicine Initiative (from the Homeless Health Initiatives Reserve), $6.1 million from Existing Reserves to fund 2-year grant agreements to Healthcare in Action (Anaheim), Celebrating Life Community Health Center (Costa Mesa), and a new Street Medicine provider (Santa Ana).

CalOptima Health
Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds
As of May 31, 2025

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	54,930,994	30,916,048	24,014,947	18,000,195[1]
Existing Reserves & HHI Transfer	87,384,530	87,384,530	65,528,126	21,856,404	-
Total	**160,315,719**	**142,315,524**	**96,444,174**	**45,871,351**	**18,000,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	847,350	552,650	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,621,311	1,000,001	HHI & DHCS
Infrastructure Projects	5,832,314	5,580,354	251,960	HHI
Capital Projects	108,247,369	77,195,575	31,051,794	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	6,344,193	3,840,337	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	**$133,185,524[1]**	**$96,444,174**	**$36,741,350**	

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments.

CalOptima Health
Fiscal Year 2024-25 Budget Allocation Changes
Reporting Changes as of May 31, 2025

Transfer Month	Line of Business	From	To	Amount	Reason to Re-Allocate Funds
July	Medi-Cal	ITS - Applications Management - System Development Enhancement for CalAIM	ITS - Applications Management - Care Management System - ZeOmega JIVA	$249,000	For ZeOmega JIVA for reporting post Go Live
July	Medi-Cal	Accounting - Purchased Services	Accounting - Printing and Postage	$20,000	To provide additional funding for toner purchase
August	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - VMWare	ITS - Infrastructure - Other Operating Expenses - IT Service Management	$38,490	To address additional licensing needs and increased costs for the Impact Guide
August	Medi-Cal	IS - Applications Management - Professional Fees - Salesforce CRM	ITS - Applications Management - Other Operating Expenses - Crowe Subscription License Fee	$38,500	To provide funding needed for license fee
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Infrastructure - Network Bandwidth Upgrade for All Sites (Wide Area Network)	$10,349	For All Sites (Wide Area Network) due to increase in expenses
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Application Development - Digital Transformation Strategy Planning and Execution Support	$32,425	Due to increase in expenses
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Applications Management - Clinical Data Sets Quality Assurance & Data Aggregator Validation	$70,000	Due to increase in expenses
August	Medi-Cal	ITS - Application Development - Other Operating Expenses - Veracode Code Scanning	Executive Office - Other Operating Expenses - CEO Leadership Alliance of Orange County (CLAOC)	$40,000	For Veracode Code Scanning To Executive Office - CEO Leadership Alliance of Orange County (CLAOC) Associations dues
September	OneCare	Communications - Purchased Services - Advertising	Communications - Professional Fees	$144,000	To provide additional funding for Runyon Saltzman for Marketing
September	Medi-Cal	ITS - Applications Management - Other Operating Expenses - HW/SW Maintenance	Executive Office - Other Operating Expenses - Professional Dues	$50,000	For coverage of expenses
September	Medi-Cal	Accounting - Purchased Services	Accounting - Other Operating Expenses - Office Supplies	$15,000	To provide additional funding needed to replenish check stock
September	PACE	PACE Administrative - Professional Fees	PACE Administrative - Other Operating Expenses - Subscriptions	$15,000	To provide funding for DHCS PACE licensing Fees
September	Medi-Cal	ITS - Application Development - Other Operating Expenses - HW/SW Maintenance	ITS - Applications Management - Other Operating Expenses - Care Management System - HealthEdge	$158,000	To help pay for Guiding Care Read Only invoice
September	OneCare	Sales & Marketing - Purchased Services	ITS - Applications Management - Professional Fees	$50,000	To engage Enthrive for additional builds to the agent portal
September	Medi-Cal	ITS - Infrastructure - Professional Fees	ITS - Infrastructure - Other Operating Expenses - Subscriptions	$32,000	To cover the renewal subscription being higher than the anticipated amount
November	PACE	PACE Marketing - Member Communication	PACE Marketing - Advertising	$84,000	To provide additional funding needed for advertisement extension
December	Medi-Cal	Executive Office - Professional Fees	Executive Office - Professional Dues	$30,000	For the Center For Corporate Innovation membership dues
January	Medi-Cal	Medical Management - Professional Fees	Medical Management - Other Operating Expenses - Training & Seminars	$40,000	For mandatory DHCS training
January	OneCare	Quality Analytics - Purchased Services	Case Management - Purchased Services	$50,000	For the OC Members Health Education training
January	Medi-Cal	ITS - Application Development - Other Operating Expenses - HW/SW Maintenance	ITS - Applications Management - Other Operating Expenses - HW/SW Maintenance	$20,000	For additional subscription license fees
January	Medi-Cal	IS - Application Development - Human Resources Electronic Record System	IS - Application Development - Human Resources Capital Management Solution Software	$40,000	Due to project schedule extension
January	Medi-Cal	IS - Application Development - Human Capital Management Integration	IS - Application Development - Human Resources Capital Management Solution Software	$63,000	Due to project schedule extension
January	Medi-Cal	IS - Infrastructure - Compliance and Risk Management System	IS - Infrastructure - Technology Asset Inventory Tracking Application	$100,000	For addition of Service Mapping and Cloud Discovery for ServiceNow
January	Medi-Cal	Claims Administration - Purchased Services	ITS - Applications Management - Professional Fees	$27,000	For Moss Adams additional audit tool customization/enhancements
January	Medi-Cal	ITS - Applications Management - Professional Fees	ITS - Applications Management - Other Operating Expenses - HW/SW Maintenance	$48,000	For Moss Adams audit tools
February	OneCare	Communications - Printing and Postage - Member Communication	Communications - Professional Fees	$105,000	To start the initial development of the Caregiver Campaign
February	PACE	PACE Marketing - Printing and Postage - Member Communication	PACE Marketing - Other Operating Expenses - Public Activities	$10,970	For promotional items
February	Medi-Cal	Facilities - Other Operating Expenses - Computer Supply/Minor Equipment	Facilities - Other Operating Expenses - Repairs & Maintenance - Building	$100,000	For 7th and 9th floor break rooms
February	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Subscriptions	ITS - Infrastructure - Other Operating Expenses - HW/SW Maintenance	$24,140	For additional Palo Alto licenses
February	Medi-Cal	Cyber Security - Other Operating Expenses - Subscriptions	ITS - Infrastructure - Professional Fees	$240,000	For the funding of new scope of work for Axis Data Masking
February	Medi-Cal	Facilities - Printing and Postage - Postage	Facilities - Professional Fees	$60,000	To fund CBRE real estate services
February	Medi-Cal	Facilities - Office Tenant Improvements	505 Building - Front/Back Entrance Door Upgrade	$30,978	For Building 505 lobby door replacement
February	Medi-Cal	Cyber Security - Other Operating Expenses - HW/SW Maintenance	Enterprise Data and Systems Integrations - Other Operating Expenses - Maint HW/SW - GASB 96 - Variable Exp	$80,000	For Edifecs contract renewal
February	Medi-Cal	ITS - Application Development - Purchased Services	ITS - Application Development - Other Operating Expenses - HW/SW Maintenance	$150,000	For Secure Auth and DayForce InView
March	Medi-Cal	Facilities - Other Operating Expenses - Computer Supply/Minor Equipment	Facilities - Other Operating Expenses - Food Services	$15,000	For restocking breakroom supplies
March	Medi-Cal	ITS - Infrastructure - Analytics and Integration Platform for Technology Issue Response and Resolution	ITS - Infrastructure - Technology Asset Inventory Tracking Application	$25,000	For ServiceNow implementation
March	Medi-Cal	ITS - Infrastructure - Computer Operating System Patch and Repair Automation	ITS - Infrastructure - Technology Asset Inventory Tracking Application	$25,000	For ServiceNow implementation
March	Medi-Cal	ITS - Cyber Security - Professional Fees	ITS - Infrastructure - Other Operating Expenses - HW/SW Maintenance	$136,000	For Microsoft support
March	Medi-Cal	ITS - Cyber Security - Professional Fees	ITS - Infrastructure - Other Operating Expenses - HW/SW Maintenance	$12,000	For Microsoft support
March	Medi-Cal	ITS - Infrastructure - Purchased Services	ITS - Applications Management - Professional Fees	$33,000	For ServiceNow consulting
March	Medi-Cal	Quality Analytics - Professional Fees	Quality Analytics - Other Operating Expenses - Incentives	$208,190	For additional Member Health reward gift cards
April	Medi-Cal	Equity and Community Health - Incentives	Equity and Community Health - Incentives	$15,000	For members completing the SDOH surveys
April	OneCare	Customer Service - Member Communication	Cultural & Linguistic Services - Purchased Services	$24,000	For additional translations and interpreter services
April	Medi-Cal	Facilities - Audio Visual Enhancements	505 Building - Building Exterior Signage Upgrade	$107,000	For 505 building rooftop building signs project
April	Medi-Cal	500 Building - Building Exterior Signage	505 Building - Building Exterior Signage Upgrade	$142,000	For 505 building rooftop building signs project
April	Medi-Cal	ITS - Infrastructure - Professional Fees	ITS - Application Development - IS - Application Development - GASB 96 - Variable Expense	$70,000	For Sitecore amendment
April	Medi-Cal	Quality Analytics - Purchased Services	Utilization Management - Purchased Services	$84,000	For Periscope In-Home Assessments invoices
April	OneCare	Quality Analytics - Purchased Services	Utilization Management - Purchased Services	$24,000	For Periscope In-Home Assessments invoices
April	Medi-Cal	Customer Service - Member Communication	Cultural & Linguistic Services - Purchased Services	$100,000	For additional translations and interpreter services
April	Medi-Cal	Financial Analysis - Professional Fees	Cultural & Linguistic Services - Purchased Services	$149,000	For additional translations and interpreter services
April	Medi-Cal	ITS - Applications Management - Professional Fees	ITS - Applications Management - Purchased Services	$215,000	From Safety Net Connect (SNC) To SNC CalAIM - Professional System
April	Medi-Cal	ITS - Applications Management - HW/SW Maintenance	ITS - Applications Management - Purchased Services	$119,000	From SafetyNet Connect (SNC) To SNC CalAIM - Development
April	Medi-Cal	ITS - Infrastructure - Server Connectivity Maintenance and Support for Server Equipment	ITS - Infrastructure - Network Connectivity Maintenance	$54,712	For Palo Alto Firewall
April	Medi-Cal	ITS - Infrastructure - Server Connectivity Maintenance and Support for Server Equipment	ITS - Infrastructure - Maintenance of Operations and Desktop Application Software and Hardware	$24,137	From HP Server Maintenance To Operations - RightFax Maintenance & Support
April	Medi-Cal	Facilities - Professional Fees	Facilities - Professional Fees	$20,000	From CAFM To Real Estate consultant
April	Medi-Cal	ITS - Applications Management - HW/SW Maintenance	ITS - Applications Management - Professional Fees	$18,000	From SNC To [New] Synegen
April	Medi-Cal	ITS - Infrastructure - Computer Supply/Minor Equipment	ITS - Application Development - Corporate Software Maintenance	$17,500	For Grammarly Business Enterprise
April	Medi-Cal	ITS - Application Development - Purchased Services	ITS - Application Development - Purchased Services	$112,500	To repurpose funds from Ushur To American Eagle
April	Medi-Cal	ITS - Applications Management - HW/SW Maintenance	ITS - Applications Management - HW/SW Maintenance	$174,000	To repurpose funds from Find Help to Safety Net Connect
April	Medi-Cal	ITS - Infrastructure - Telecom Expense Management System, Other Ongoing Services	ITS - Applications Management - Cloud Platform Assistance, Work Station Management and Miscellaneous	$120,000	For ServiceNow Consulting SPM Phase 3
April	OneCare	Communications - Member Communication	Communications - Advertising	$150,000	For advertising sponsorship and outreach
May	Medi-Cal	Enterprise Project Mgmt Office - Training & Seminar	Strategic Development - Training & Seminar	$14,000	For Leadership Academy
May	Medi-Cal	ITS - Infrastructure - Misc HW/SW Equip Sup	IS - Cyber Security - Subscriptions	$249,000	For Zscaler
May	Medi-Cal	ITS - Infrastructure - Misc HW/SW Equip Sup	Communications - Professional Fees	$180,000	For Maricich Health
May	Medi-Cal	Medical Mgmt - Training & Seminar	Medical Mgmt - Professional Fees	$20,000	For PA consulting fees
May	OneCare	Equity and Community Health - Purchased Services	Quality Analytics - Member Communication	$45,000	For mailing and fulfillment costs for OneCare

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

Preliminary Unaudited Financial Summary June 30, 2025

Board of Directors Meeting

August 7, 2025

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Financial Highlights
June 2025

June 2025					July 2024 - June 2025			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
904,213	903,120	1,093	0.1%	Member Months	10,924,986	10,813,950	111,036	1.0%
384,030,839	360,241,067	23,789,772	6.6%	Revenues	5,027,901,464	4,292,620,541	735,280,923	17.1%
220,776,305	352,183,764	131,407,459	37.3%	Medical Expenses	4,514,755,243	4,255,739,149	(259,016,094)	(6.1%)
28,608,305	26,728,072	(1,880,234)	(7.0%)	Administrative Expenses	261,329,500	299,888,124	38,558,623	12.9%
134,646,229	**(18,670,769)**	**153,316,998**	**821.2%**	**Operating Margin**	**251,816,720**	**(263,006,732)**	**514,823,452**	**195.7%**
				Non-Operating Income (Loss)				
19,887,991	6,666,740	13,221,251	198.3%	Net Investment Income/Expense	195,765,744	80,000,000	115,765,744	144.7%
5,293,369	(1,178,834)	6,472,203	549.0%	Grant Expense	(8,959,554)	(14,055,000)	5,095,446	36.3%
(88,098,111)	-	(88,098,111)	(100.0%)	Community Reinvestment	(88,098,111)	-	(88,098,111)	(100.0%)
(234,337)	(117,268)	(117,069)	(99.8%)	Other Income/Expense	4,976,727	(1,407,348)	6,384,075	453.6%
(63,151,087)	**5,370,638**	**(68,521,725)**	**(1,275.9%)**	**Total Non-Operating Income (Loss)**	**103,684,806**	**64,537,652**	**39,147,154**	**60.7%**
71,495,142	**(13,300,131)**	**84,795,273**	**637.6%**	**Change in Net Assets**	**355,501,527**	**(198,469,080)**	**553,970,606**	**279.1%**
57.5%	*97.8%*	*(40.3%)*		*Medical Loss Ratio*	*89.8%*	*99.1%*	*(9.3%)*	
7.4%	*7.4%*	*(0.0%)*		*Administrative Loss Ratio*	*5.2%*	*7.0%*	*1.8%*	
35.1%	*(5.2%)*	*40.2%*		*Operating Margin Ratio*	*5.0%*	*(6.1%)*	*11.1%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
91.5%	*92.9%*	*(1.4%)*		**Adjusted MLR*	*86.7%*	*94.2%*	*(7.5%)*	
7.4%	*7.4%*	*(0.0%)*		**Adjusted ALR*	*5.6%*	*7.0%*	*1.4%*	

*Adjusted MLR/ALR excludes estimated Board-approved Provider Rate increases, Directed Payments and Community Reinvestment accruals, but includes costs associated with CalOptima Health's Digital Transformation Strategy (DTS) budget

CalOptima Health

Financial Highlights Notes: June 2025

- Notable events/items in June 2025
  - Due to updated Community Reinvestment guidance from the Department of Health Care Services (DHCS):
    - The estimated program accrual for Calendar Year (CY) 2024 and 2025 Year To Date (YTD) was reduced by $67.1 million
    - The remaining balance of $88.1 million was recategorized from Other Medical Expenses to Non-Operating Expenses
  - Grant expense was a YTD true-up to include prior year adjustments
  - Favorable revenue due primarily to:
    - The revised CY 2025 draft rates received in December were favorable compared to budget assumptions.

CalOptima Health

FY 2024-25: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) June 2025: $71.5 million, favorable to budget $84.8 million or 637.6% primarily due to:
    - Release of CY 2024 Community Reinvestment accruals due to updated guidance from DHCS
    - Medi-Cal (MC) enrollment and CY 2025 premium capitation rates offset by higher claims utilization
  - YTD July 2024 – June 2025: $355.5 million, favorable to budget $554.0 million or 279.1% primarily due to:
    - Favorable net investment income, premium capitation rates and enrollment in the MC Line of Business (LOB)

CalOptima Health

FY 2024-25 Management Summary (cont.)

- Enrollment
  - MTD: 904,213 members, favorable to budget 1,093 or 0.1%
  - YTD: 10,924,986 member months, favorable to budget 111,036 or 1.0%

FY 2024-25 Management Summary (cont.)

- Revenue
  - MTD: $384.0 million, favorable to budget $23.8 million or 6.6% driven by:
    - $28.5 million in MC LOB due primarily to favorable enrollment and CY 2025 premium capitation rates
    - Offset by unfavorable variances in MC due to $4.2 million from Proposition 56, Enhanced Care Management (ECM) and Unsatisfactory Immigration Status (UIS) risk corridors
  - YTD: $5,027.9 million, favorable to budget $735.3 million or 17.1% driven by:
    - MC LOB due to favorable enrollment, premium capitation rates, and CY 2022 and 2023 Hospital Directed Payments (DP)

CalOptima Health

FY 2024-25 Management Summary (cont.)

- Medical Expenses
  - MTD: $220.8 million, favorable to budget $131.4 million or 37.3% driven by MC LOB:
    - Other Medical Expenses favorable variance of $140.4 million due to updated estimate for Community Reinvestment and recategorization to Non-Operating Expenses
    - Net unfavorable variance of $9.8 million from all other categories

FY 2024-25 Management Summary (cont.)

- Medical Expenses (cont.)
  - YTD: $4,514.8 million, unfavorable to budget $259.0 million or 6.1% driven by:
    - $280.8 million in MC Other Medical Expense due primarily to CY 2022 and 2023 Hospital DP and Community Reinvestment
    - Offset by $15.9 million in MC Incentive Payments expense due to Hospital Quality Program (HQP)

FY 2024-25 Management Summary (cont.)

- Administrative Expenses
  - MTD: $28.6 million, unfavorable to budget $1.9 million or 7.0% due to net change in Pension and Other Post-Employment Benefits (OPEB)
  - YTD: $261.3 million, favorable to budget $38.6 million or 12.9%

FY 2024-25 Management Summary (cont.)

- Non-Operating Income (Loss)
  - MTD: ($63.2) million, unfavorable to budget $68.5 million or 1,275.9% primarily due to a recategorization of Community Reinvestment offset by favorable Net Investment Income and Grant Expense of $19.7 million
  - YTD: $103.7 million, favorable to budget $39.1 million or 60.7% primarily due to favorable Net Investment Income offset by Community Reinvestment and Grant Expenses

FY 2024-25: Key Financial Ratios

- Medical Loss Ratio (MLR)

		Actual	Budget	Variance (%)
MTD	MLR	57.5%	97.8%	(40.3%)
	Adjusted MLR*	91.5%	92.9%	(1.4%)
YTD	MLR	89.8%	99.1%	(9.3%)
	Adjusted MLR*	86.7%	94.2%	(7.5%)

- Administrative Loss Ratio (ALR)

		Actual	Budget	Variance (%)
MTD	ALR	7.4%	7.4%	0.0%
	Adjusted ALR*	7.4%	7.4%	0.0%
YTD	ALR	5.2%	7.0%	1.8%
	Adjusted ALR*	5.6%	7.0%	1.4%

* Adjusted MLR/ALR excludes estimated Board-approved Provider Rate Increases, Directed Payments and Community Reinvestment Accruals, but include costs associated with DTS.

CalOptima Health

FY 2024:25: Key Financials Ratios (cont.)

- Balance Sheet Ratios
  - Current ratio*: 1.7
  - Board Designated Reserve level: 3.79
  - Statutory Designated Reserve level: 1.02
  - Net-position: $2.8 billion, including required TNE of $129.3 million

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

Enrollment Summary: June 2025

June 2025					July 2024 - June 2025			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
151,802	139,325	12,477	9.0%	SPD	1,770,805	1,652,037	118,768	7.2%
258,690	272,166	(13,476)	(5.0%)	TANF Child	3,184,076	3,266,672	(82,596)	(2.5%)
128,652	138,593	(9,941)	(7.2%)	TANF Adult	1,565,536	1,657,817	(92,281)	(5.6%)
2,584	2,595	(11)	(0.4%)	LTC	30,071	31,227	(1,156)	(3.7%)
335,333	322,818	12,515	3.9%	MCE	4,048,069	3,876,389	171,680	4.4%
8,973	9,543	(570)	(6.0%)	WCM	113,007	114,625	(1,618)	(1.4%)
886,034	**885,040**	**994**	**0.1%**	**Medi-Cal Total**	**10,711,564**	**10,598,767**	**112,797**	**1.1%**
17,664	**17,586**	**78**	**0.4%**	**OneCare**	**207,356**	**209,408**	**(2,052)**	**(1.0%)**
515	**494**	**21**	**4.3%**	**PACE**	**6,066**	**5,775**	**291**	**5.0%**
539	**568**	**(29)**	**(5.1%)**	**MSSP***	**6,213**	**6,816**	**(603)**	**(8.8%)**
904,213	**903,120**	**1,093**	**0.1%**	**CalOptima Health Total**	**10,924,986**	**10,813,950**	**111,036**	**1.0%**

*MSSP enrollment is included in Medi-Cal total

Consolidated Revenue & Expenses: June 2025 MTD

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	886,034	17,664		515	539		904,213
REVENUES							
Capitation Revenue	$ 345,037,926	$ 33,143,828	$ 699,715	$ 4,943,262	$ 206,109	$ -	$ 384,030,839
Total Operating Revenue	**345,037,926**	**33,143,828**	**699,715**	**4,943,262**	**206,109**	**-**	**384,030,839**
MEDICAL EXPENSES							
Provider Capitation	116,435,779	13,973,584	45,758				130,455,121
Claims	133,475,857	6,894,401		2,011,556			142,381,814
MLTSS	52,962,773			64,300	42,782		53,069,854
Prescription Drugs		9,247,351		549,540			9,796,891
Case Mgmt & Other Medical	(119,258,761)	2,265,916		1,873,208	192,260		(114,927,377)
Total Medical Expenses	**183,615,648**	**32,381,253**	**45,758**	**4,498,604**	**235,042**	**-**	**220,776,305**
Medical Loss Ratio	*53.2%*	*97.7%*	*6.5%*	*91.0%*	*114.0%*	*0.0%*	*57.5%*
GROSS MARGIN	**161,422,279**	**762,574**	**653,957**	**444,658**	**(28,933)**	**-**	**163,254,534**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	12,650,049	741,712		190,171	106,417		13,688,350
Non-Salary Operating Expenses	6,175,740	1,259,893		189,036	1,423	982,129	8,608,221
Depreciation & Amortization	888,649			980			889,629
Other Operating Expenses	4,661,388	66,042		(5,932)	11,376		4,732,874
Indirect Cost Allocation, Occupancy	1,011,943	(332,499)		8,091	1,695		689,231
Total Administrative Expenses	**25,387,769**	**1,735,149**	**-**	**382,347**	**120,911**	**982,129**	**28,608,305**
Administrative Loss Ratio	*7.4%*	*5.2%*	*0.0%*	*7.7%*	*58.7%*	*0.0%*	*7.4%*
Operating Income/(Loss)	**136,034,509**	**(972,574)**	**653,957**	**62,311**	**(149,845)**	**(982,129)**	**134,646,229**
Investments and Other Non-Operating	(88,193,235)						(63,151,087)
CHANGE IN NET ASSETS	**$ 47,841,274**	**$ (972,574)**	**$ 653,957**	**$ 62,311**	**$ (149,845)**	**$ (982,129)**	**$ 71,495,142**
BUDGETED CHANGE IN NET ASSETS	(16,626,050)	(1,003,752)	-	(13,047)	(111,249)	(916,671)	(13,300,131)
Variance to Budget - Fav/(Unfav)	$ 64,467,324	$ 31,178	$ 653,957	$ 75,358	$ (38,596)	$ (65,458)	$ 84,795,273

CalOptima Health

Consolidated Revenue & Expenses: June 2025 YTD

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	10,711,564	207,356		6,066	6,213		10,924,986
REVENUES							
Capitation Revenue	$ 4,566,766,941	$ 406,152,504	$ (2,497,650)	$ 54,674,495	$ 2,805,173	$ -	$ 5,027,901,464
Total Operating Revenue	**4,566,766,941**	**406,152,504**	**(2,497,650)**	**54,674,495**	**2,805,173**	**-**	**5,027,901,464**
MEDICAL EXPENSES							
Provider Capitation	1,370,782,567	168,510,220	(1,407,279)				1,537,885,508
Claims	1,586,045,458	74,500,922	(184,151)	20,211,637			1,680,573,866
MLTSS	595,758,700			280,493	476,126		596,515,319
Prescription Drugs		108,677,633		6,982,244			115,659,877
Case Mgmt & Other Medical	543,793,197	22,169,964		15,896,276	2,261,236		584,120,673
Total Medical Expenses	**4,096,379,922**	**373,858,739**	**(1,591,430)**	**43,370,650**	**2,737,362**	**-**	**4,514,755,243**
Medical Loss Ratio	*89.7%*	*92.0%*	*63.7%*	*79.3%*	*97.6%*	*0.0%*	*89.8%*
GROSS MARGIN	**470,387,019**	**32,293,765**	**(906,220)**	**11,303,846**	**67,811**	**-**	**513,146,220**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	139,228,904	12,515,138		2,072,391	1,238,332		155,054,765
Non-Salary Operating Expenses	44,482,238	7,888,623		1,123,934	17,054	1,647,163	55,159,012
Depreciation & Amortization	9,578,774			11,691			9,590,465
Other Operating Expenses	35,715,219	998,043		94,095	96,238		36,903,595
Indirect Cost Allocation, Occupancy	(7,434,996)	11,772,975		201,044	82,639		4,621,662
Total Administrative Expenses	**221,570,139**	**33,174,780**	**-**	**3,503,156**	**1,434,263**	**1,647,163**	**261,329,500**
Administrative Loss Ratio	*4.9%*	*8.2%*	*0.0%*	*6.4%*	*51.1%*	*0.0%*	*5.2%*
Operating Income/(Loss)	**248,816,880**	**(881,015)**	**(906,220)**	**7,800,689**	**(1,366,452)**	**(1,647,163)**	**251,816,720**
Investments and Other Non-Operating	(82,565,688)						103,684,806
CHANGE IN NET ASSETS	**$ 166,251,192**	**$ (881,015)**	**$ (906,220)**	**$ 7,800,689**	**$ (1,366,452)**	**$ (1,647,163)**	**$ 355,501,527**
BUDGETED CHANGE IN NET ASSETS	(242,508,008)	(12,700,621)	-	(939,556)	(1,358,546)	(5,500,001)	(198,469,080)
Variance to Budget - Fav/(Unfav)	$ 408,759,200	$ 11,819,606	$ (906,220)	$ 8,740,245	$ (7,906)	$ 3,852,838	$ 553,970,606

CalOptima Health

Balance Sheet: As of June 2025

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$475,203,955	Accounts Payable	$233,986,507
Short-term Investments	1,340,926,601	Medical Claims Liability	1,047,737,339
Capitation Receivable	653,537,573	Accrued Payroll Liabilities	29,845,788
Receivables - Other	95,574,162	Deferred Revenue	22,054,562
Prepaid Expenses	11,183,062	Other Current Liabilities	-
Total Current Assets	**2,576,425,353**	Capitation and Withholds	153,993,365
		Total Current Liabilities	**1,487,617,562**
Capital Assets		**Other Liabilities**	
Capital Assets	188,184,217	GASB 96 Subscription Liabilities	16,837,359
Less Accumulated Depreciation	(89,561,512)	Community Reinvestment	88,098,111
Capital Assets, Net of Depreciation	**98,622,705**	Capital Lease Payable	245,394
		Postemployment Health Care Plan	17,249,000
Other Assets		Net Pension Liabilities	5,840,992
Restricted Deposits	300,000	**Total Other Liabilities**	**128,270,856**
Board Designated Reserves	1,584,426,734		
Statutory Designated Reserves	132,380,774	**TOTAL LIABILITIES**	**1,615,888,418**
Total Other Assets	**1,717,107,508**		
TOTAL ASSETS	**4,392,155,566**	**Deferred Inflows**	**4,309,519**
Deferred Outflows	**28,626,072**	**Net Position**	
		Required TNE	129,341,855
		Funds in Excess of TNE	2,671,241,846
		TOTAL NET POSITION	**2,800,583,701**
TOTAL ASSETS & DEFERRED OUTFLOWS	**4,420,781,638**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**4,420,781,638**

CalOptima Health

Board Designated Reserve and TNE Analysis: As of June 2025

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	792,253,537				
MetLife Tier One	792,173,197				
Board Designated Reserves	1,584,426,734	1,044,702,453	1,671,523,924	539,724,282	(87,097,190)
Current Reserve Level (X months of average monthly revenue) [1]	*3.79*	*2.50*	*4.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	66,314,587				
MetLife Tier Two	66,066,187				
Statutory Designated Reserves	132,380,774	129,341,855	142,276,041	3,038,918	(9,895,267)
Current Reserve Level (X min. TNE) [1]	*1.02*	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

CalOptima Health

Spending Plan: As of June 2025

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 6/30/2025	**$2,800.6**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,584.4**			**56.6%**
	Statutory Designated Reserve[1]	**$132.4**			**4.7%**
	Capital Assets, net of Depreciation	**$98.6**			**3.5%**
Resources Allocated[3]	Homeless Health Initiative[2]	$20.8	$65.9	$45.1	0.7%
	Housing and Homelessness Incentive Program[2]	25.8	87.4	61.5	0.9%
	Intergovernmental Transfers (IGT)[4]	45.1	52.1	6.9	1.6%
	Digital Transformation and Workplace Modernization[3]	29.2	100.0	70.8	1.0%
	CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
	CalFresh and Redetermination Outreach Strategy	1.7	6.0	4.3	0.1%
	Coalition of Orange County Community Health Centers Grant	25.7	50.0	24.3	0.9%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	General Awareness Campaign	0.4	4.7	4.3	0.0%
	Member Health Needs Assessment	0.6	1.3	0.7	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	120.3	153.5	33.2	4.3%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.4%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program Grant	3.0	5.0	2.0	0.1%
	Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program Grant	1.5	2.7	1.2	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	44.5	50.0	5.5	1.6%
	Distribution Event - Naloxone Grant	2.2	15.0	12.8	0.1%
	Garden Grove Bldg. Improvement	9.8	10.5	0.7	0.4%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.4%
	Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
	Outreach Strategy for newly eligible Adult Expansion members	3.2	7.6	4.3	0.1%
	Quality Initiatives from unearned Pay for Value Program	18.8	23.3	4.5	0.7%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.3	1.2	0.9	0.0%
	Medi-Cal Provider Rate Increases	315.7	526.2	210.5	11.3%
	Homeless Prevention and Stabilization Pilot Program	0.2	0.3	0.0	0.0%
	OneCare Member Engagement and Education	0.3	0.3	0.0	0.0%
	Subtotal:	**$720.2**	**$1,236.7**	**$516.5**	**25.7%**
Resources Available for New Initiative	Unallocated/Unassigned[1]	**$265.0**			**9.5%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 168 days of CalOptima Health's current operations.
[2] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.
[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.
[4] On June 5, 2025, the Board of Directors approved the close out of Board-approved initiatives and transfer of remaining funds back to unallocated reserves.

CalOptima Health

Homeless Health Initiative and Allocated Funds: As of June 2025

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
HHI - IGT'S	59,900,000	59,831,301	45,150,696	14,680,605	68,699
HHI - Existing Reserves	6,100,000	6,100,000	-	6,100,000	-
HHIP	40,100,000	40,100,000	-	40,100,000	-
Total	**106,100,000**	**106,031,301**	**45,150,696**	**60,880,605**	**68,699**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-	IGT's
Recuperative Care	6,194,190	6,194,190	-	IGT's
Medical Respite	250,000	250,000	-	IGT's
Day Habilitation (County for HomeKey)	2,500,000	-	2,500,000	IGT's
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-	IGT's
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-	IGT's
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522	IGT's
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	925,540	37,721	IGT's
FQHC (Community Health Center) Expansion	21,902	21,902	-	IGT's
HCAP and CalOptima Health Days	9,888,914	4,334,952	5,553,961	IGT's
Vaccination Intervention and Member Incentive Strategy[1]	54,649	54,649	-	IGT's
Street Medicine[2]	14,376,652	7,593,244	6,783,408	IGT's & Existing Reserves
Outreach and Engagement	7,000,000	1,138,008	5,861,992	IGT's
Housing and Homelessness Incentive Program (HHIP)[3]	40,100,000	-	40,100,000	IGT's & Existing Reserves
Subtotal of Approved Initiatives	**106,031,301**	**45,150,696**	**60,880,604**	
Transfer of funds to HHIP[3]	(40,100,000)	-	(40,100,000)	
Program Total	**65,931,301**	**45,150,696**	**20,780,604**	

[1]On June 5, 2025 the Board of Directors approved the close out of the Vaccination Intervention and Member Incentive Strategy program and transfer of the remaining funds of $68,699 to unallocated reserves for new initiatives

[2]On March 19, 2025, CalOptima Health's Board of Directors approved $4.3 million from existing reserves to fund a new Street Medicine Program (Santa Ana). On March 7, 2024, CalOptima Health's Board of Directors approved $5.0 million to expand the Street Medicine Program. $3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and $1.8 million from existing reserves to fund 2-year agreements with Healthcare in Action (Anaheim) and Celebrating Life Community Health Center (Costa Mesa)

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

CalOptima Health

Housing and Homelessness Incentive Program: As of June 2025

Summary by Funding Source:	Total Funds[1]	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	54,930,994	30,916,048	24,014,947	$18,000,195
Existing Reserves & HHI Transfer	87,384,530	87,384,530	61,543,126	25,841,404	-
Total	**160,315,719**	**142,315,524**	**92,459,174**	**49,856,351**	**18,000,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	862,350	537,650	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,621,311	1,000,001	HHI & DHCS
Infrastructure Projects	5,832,314	5,580,354	251,960	HHI
Capital Projects	108,247,369	73,195,575	35,051,794	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	6,344,193	3,840,337	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	**$133,185,524[1]**	**$92,459,173**	**$40,726,351**	

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments

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CalOptima Health

UNAUDITED FINANCIAL STATEMENTS

June 30, 2025

Preliminary Reports as of July 18, 2025

Final fiscal year report is subject to change following financial audit

Back to Agenda

Table of Contents

Financial Highlights 3
Full-Time Equivalent (FTE) Data 4
Statement of Revenues and Expenses – Consolidated Month to Date 5
Statement of Revenues and Expenses – Consolidated Year to Date 6
Statement of Revenues and Expenses by LOB – Consolidated Month to Date 7
Statement of Revenues and Expenses by LOB – Consolidated Year to Date 8
Highlights – Consolidated 9
Enrollment Summary 10
Enrollment Trend by Network 11
Highlights – Enrollment 12
Statement of Revenues and Expenses – Medi-Cal 13
Highlights – Medi-Cal 14
Statement of Revenues and Expenses – OneCare 15
Highlights – OneCare 16
Statement of Revenues and Expenses – PACE 17
Statement of Revenues and Expenses – MSSP 18
Statement of Revenues and Expenses – OneCare Connect 19
Statement of Revenues and Expenses – Covered CA 20
Statement of Revenues and Expenses – 505 City Parkway 21
Statement of Revenues and Expenses – 500 City Parkway 22
Statement of Revenues and Expenses – 7900 Garden Grove Blvd 23
Highlights – PACE, MSSP, OneCare Connect, Covered CA, 505 & 500 City Parkway and 7900 Garden Grove Blvd 24
Balance Sheet 25
Highlights – Balance Sheet 26
Board Designated Reserve and, TNE Analysis 27
Statement of Cash Flow 28
Spending Plan 29
Key Financial Indicators 30
Digital Transformation Strategy 31
Homeless Health Initiatives 32
Housing and Homelessness Incentive Program 33
Budget Allocation Changes 34

Back to Agenda

CalOptima Health - Consolidated
Financial Highlights
For the Twelve Months Ending June 30, 2025

June 2025					July 2024 - June 2025			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
904,213	903,120	1,093	0.1%	Member Months	10,924,986	10,813,950	111,036	1.0%
384,030,839	360,241,067	23,789,772	6.6%	Revenues	5,027,901,464	4,292,620,541	735,280,923	17.1%
220,776,305	352,183,764	131,407,459	37.3%	Medical Expenses	4,514,755,243	4,255,739,149	(259,016,094)	(6.1%)
28,608,305	26,728,072	(1,880,234)	(7.0%)	Administrative Expenses	261,329,500	299,888,124	38,558,623	12.9%
134,646,229	**(18,670,769)**	**153,316,998**	**821.2%**	**Operating Margin**	**251,816,720**	**(263,006,732)**	**514,823,452**	**195.7%**
				Non-Operating Income (Loss)				
19,887,991	6,666,740	13,221,251	198.3%	Net Investment Income/Expense	195,765,744	80,000,000	115,765,744	144.7%
5,293,369	(1,178,834)	6,472,203	549.0%	Grant Expense	(8,959,554)	(14,055,000)	5,095,446	36.3%
(88,098,111)	-	(88,098,111)	(100.0%)	Community Reinvestment	(88,098,111)	-	(88,098,111)	(100.0%)
(234,337)	(117,268)	(117,069)	(99.8%)	Other Income/Expense	4,976,727	(1,407,348)	6,384,075	453.6%
(63,151,087)	**5,370,638**	**(68,521,725)**	**(1,275.9%)**	**Total Non-Operating Income (Loss)**	**103,684,806**	**64,537,652**	**39,147,154**	**60.7%**
71,495,142	**(13,300,131)**	**84,795,273**	**637.6%**	**Change in Net Assets**	**355,501,527**	**(198,469,080)**	**553,970,606**	**279.1%**
57.5%	*97.8%*	*(40.3%)*		*Medical Loss Ratio*	*89.8%*	*99.1%*	*(9.3%)*	
7.4%	*7.4%*	*(0.0%)*		*Administrative Loss Ratio*	*5.2%*	*7.0%*	*1.8%*	
35.1%	*(5.2%)*	*40.2%*		*Operating Margin Ratio*	*5.0%*	*(6.1%)*	*11.1%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
91.5%	*92.9%*	*(1.4%)*		**Adjusted MLR*	*86.7%*	*94.2%*	*(7.5%)*	
7.4%	*7.4%*	*(0.0%)*		**Adjusted ALR*	*5.6%*	*7.0%*	*1.4%*	

*Adjusted MLR /ALR excludes estimated Board-approved Provider Rate increases, Directed Payments and Community Reinvestment Accruals, but includes costs associated with CalOptima Health's Digital Transformation Strategy (DTS) budget.

CalOptima Health - Consolidated
Full Time Equivalent (FTE) Data
For the Twelve Months Ending June 30, 2025

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1,325	1,361	36
OneCare	162	186	24
PACE	110	113	3
MSSP	22	25	3
Total	1,619	1,685	66

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	15,695	16,330	634
OneCare	2,039	2,233	193
PACE	1,288	1,356	68
MSSP	259	300	41
Total	19,282	20,218	937

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	669	650	(19)
OneCare	109	95	(14)
PACE	5	4	(1)
MSSP	24	23	(1)
Consolidated	558	536	(22)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	682	649	(33)
OneCare	102	94	(8)
PACE	5	4	(1)
MSSP	24	23	(1)
Consolidated	567	535	(32)

Open FTE			
	Total	Medical	Admin
Medi-Cal	54	20	34
OneCare	15	8	7
PACE	6	5	1
MSSP	0	0	0
Total	75	33	42

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending June 30, 2025

MEMBER MONTHS		904,213		903,120		1,093
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$345,037,926	$389.42	$319,818,236	$361.36	$25,219,690	$28.06
OneCare	33,143,828	1,876.35	36,029,425	2,048.76	(2,885,598)	(172.41)
OneCare Connect	699,715		-		699,715	-
PACE	4,943,262	9,598.57	4,139,885	8,380.33	803,377	1,218.24
MSSP	206,109	382.39	253,521	446.34	(47,412)	(63.95)
Covered CA	-	0.00	-	0.00	-	0.00
Total Operating Revenue	384,030,839	424.71	360,241,067	398.89	23,789,772	25.82
MEDICAL EXPENSES						
Medi-Cal	183,615,648	207.23	314,266,131	355.09	130,650,483	147.86
OneCare	32,381,253	1,833.18	33,817,758	1,922.99	1,436,505	89.81
OneCare Connect	45,758				(45,758)	0.00
PACE	4,498,604	8,735.15	3,859,128	7,812.00	(639,476)	(923.15)
MSSP	235,042	436.07	240,747	423.85	5,705	(12.22)
Covered CA		-		-	-	-
Total Medical Expenses	220,776,305	244.16	352,183,764	389.96	131,407,459	145.80
GROSS MARGIN	163,254,534	180.55	8,057,303	8.93	155,197,231	171.62
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	13,688,350	15.14	13,224,867	14.64	(463,483)	(0.50)
Professional Fees	4,198,883	4.64	4,290,089	4.75	91,206	0.11
Purchased Services	3,463,366	3.83	3,215,263	3.56	(248,104)	(0.27)
Printing & Postage	945,971	1.05	653,793	0.72	(292,178)	(0.33)
Depreciation & Amortization	889,629	0.98	1,027,967	1.14	138,338	0.16
Other Expenses	4,732,874	5.23	3,872,036	4.29	(860,838)	(0.94)
Indirect Cost Allocation, Occupancy	689,231	0.76	444,057	0.49	(245,174)	(0.27)
Total Administrative Expenses	28,608,305	31.64	26,728,072	29.60	(1,880,234)	(2.04)
NET INCOME (LOSS) FROM OPERATIONS	134,646,229	148.91	(18,670,769)	(20.67)	153,316,998	169.58
INVESTMENT INCOME						
Interest Income	13,369,503	14.79	6,666,740	7.38	6,702,763	7.41
Realized Gain/(Loss) on Investments	350,360	0.39	-	-	350,360	0.39
Unrealized Gain/(Loss) on Investments	6,168,129	6.82	-	-	6,168,129	6.82
Total Investment Income	19,887,991	21.99	6,666,740	7.38	13,221,251	14.61
GRANT EXPENSE	5,293,369	5.85	(1,178,834)	(1.31)	6,472,203	7.16
COMMUNITY REINVESTMENT	(88,098,111)	(97.43)	-	-	(88,098,111)	(97.43)
OTHER INCOME/EXPENSE	(234,337)	(0.26)	(117,268)	(0.13)	(117,069)	(0.13)
CHANGE IN NET ASSETS	**71,495,142**	**79.07**	**(13,300,131)**	**(14.73)**	**84,795,273**	**93.80**
MEDICAL LOSS RATIO	**57.5%**		**97.8%**		**(40.3%)**	
ADMINISTRATIVE LOSS RATIO	**7.4%**		**7.4%**		**(0.0%)**	

Back to Agenda

CalOptima Health- Consolidated - Year to Date
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2025

MEMBER MONTHS		10,924,986		10,813,950		111,036
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$4,566,766,941	$426.34	$3,814,724,802	$359.92	$752,042,139	$66.42
OneCare	406,152,504	1,958.72	426,644,977	2,037.39	(20,492,473)	(78.67)
OneCare Connect	(2,497,650)		-		(2,497,650)	0.00
PACE	54,674,495	9,013.27	48,208,554	8,347.80	6,465,941	665.47
MSSP	2,805,173	451.50	3,042,208	446.33	(237,035)	5.17
Covered CA	-	0.00	-	0.00	-	0.00
Total Operating Revenue	5,027,901,464	460.22	4,292,620,541	396.95	735,280,923	63.27
MEDICAL EXPENSES						
Medi-Cal	4,096,379,922	382.43	3,806,534,058	359.15	(289,845,864)	(23.28)
OneCare	373,858,739	1,802.98	400,732,809	1,913.65	26,874,070	110.67
OneCare Connect	(1,591,430)				1,591,430	0.00
PACE	43,370,650	7,149.79	45,583,384	7,893.23	2,212,734	743.44
MSSP	2,737,362	440.59	2,888,898	423.84	151,536	(16.75)
Covered CA		0.00		0.00	-	0.00
Total Medical Expenses	4,514,755,243	413.25	4,255,739,149	393.54	(259,016,094)	(19.71)
GROSS MARGIN	513,146,220	46.97	36,881,392	3.41	476,264,828	43.56
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	155,054,765	14.19	161,940,257	14.98	6,885,492	0.79
Professional Fees	19,297,821	1.77	27,763,892	2.57	8,466,070	0.80
Purchased Services	29,268,759	2.68	36,729,055	3.40	7,460,296	0.72
Printing & Postage	6,592,432	0.60	9,089,315	0.84	2,496,883	0.24
Depreciation & Amortization	9,590,465	0.88	12,335,505	1.14	2,745,040	0.26
Other Expenses	36,903,595	3.38	46,705,170	4.32	9,801,575	0.94
Indirect Cost Allocation, Occupancy	4,621,662	0.42	5,324,930	0.49	703,268	0.07
Total Administrative Expenses	261,329,500	23.92	299,888,124	27.73	38,558,623	3.81
NET INCOME (LOSS) FROM OPERATIONS	251,816,720	23.05	(263,006,732)	(24.32)	514,823,452	47.37
INVESTMENT INCOME						
Interest Income	172,112,379	15.75	80,000,000	7.40	92,112,379	8.35
Realized Gain/(Loss) on Investments	5,490,569	0.50	-	0.00	5,490,569	0.50
Unrealized Gain/(Loss) on Investments	18,162,797	1.66	-	0.00	18,162,797	1.66
Total Investment Income	195,765,744	17.92	80,000,000	7.40	115,765,744	10.52
GRANT EXPENSE	(8,959,554)	(0.82)	(14,055,000)	(1.30)	5,095,446	0.48
COMMUNITY REINVESTMENT	(88,098,111)	(8.06)	-	0.00	(88,098,111)	(8.06)
OTHER INCOME/EXPENSE	4,976,727	0.46	(1,407,348)	(0.13)	6,384,075	0.59
CHANGE IN NET ASSETS	**355,501,527**	**32.54**	**(198,469,080)**	**(18.35)**	**553,970,606**	**50.89**
MEDICAL LOSS RATIO	**89.8%**		**99.1%**		**(9.3%)**	
ADMINISTRATIVE LOSS RATIO	**5.2%**		**7.0%**		**1.8%**	

Back to Agenda

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending June 30, 2025

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	886,034	17,664		515	539	-	904,213
REVENUES							
Capitation Revenue	$ 345,037,926	$ 33,143,828	$ 699,715	$ 4,943,262	$ 206,109	$ -	$ 384,030,839
Total Operating Revenue	**345,037,926**	**33,143,828**	**699,715**	**4,943,262**	**206,109**	**-**	**384,030,839**
MEDICAL EXPENSES							
Provider Capitation	116,435,779	13,973,584	45,758				130,455,121
Claims	133,475,857	6,894,401		2,011,556			142,381,814
MLTSS	52,962,773			64,300	42,782		53,069,854
Prescription Drugs		9,247,351		549,540			9,796,891
Case Mgmt & Other Medical	(119,258,761)	2,265,916		1,873,208	192,260		(114,927,377)
Total Medical Expenses	**183,615,648**	**32,381,253**	**45,758**	**4,498,604**	**235,042**	**-**	**220,776,305**
Medical Loss Ratio	*53.2%*	*97.7%*	*6.5%*	*91.0%*	*114.0%*	*0.0%*	*57.5%*
GROSS MARGIN	**161,422,279**	**762,574**	**653,957**	**444,658**	**(28,933)**	**-**	**163,254,534**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	12,650,049	741,712		190,171	106,417		13,688,350
Non-Salary Operating Expenses	6,175,740	1,259,893		189,036	1,423	982,129	8,608,221
Depreciation & Amortization	888,649			980			889,629
Other Operating Expenses	4,661,388	66,042		(5,932)	11,376		4,732,874
Indirect Cost Allocation, Occupancy	1,011,943	(332,499)		8,091	1,695		689,231
Total Administrative Expenses	**25,387,769**	**1,735,149**	**-**	**382,347**	**120,911**	**982,129**	**28,608,305**
Administrative Loss Ratio	*7.4%*	*5.2%*	*0.0%*	*7.7%*	*58.7%*	*0.0%*	*7.4%*
Operating Income/(Loss)	**136,034,509**	**(972,574)**	**653,957**	**62,311**	**(149,845)**	**(982,129)**	**134,646,229**
Investments and Other Non-Operating	(88,193,235)						(63,151,087)
CHANGE IN NET ASSETS	**$ 47,841,274**	**$ (972,574)**	**$ 653,957**	**$ 62,311**	**$ (149,845)**	**$ (982,129)**	**$ 71,495,142**
BUDGETED CHANGE IN NET ASSETS	(16,626,050)	(1,003,752)	-	(13,047)	(111,249)	(916,671)	(13,300,131)
Variance to Budget - Fav/(Unfav)	$ 64,467,324	$ 31,178	$ 653,957	$ 75,358	$ (38,596)	$ (65,458)	$ 84,795,273

Back to Agenda

CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Twelve Months Ending June 30, 2025

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	10,711,564	207,356		6,066	6,213	-	10,924,986
REVENUES							
Capitation Revenue	$ 4,566,766,941	$ 406,152,504	$ (2,497,650)	$ 54,674,495	$ 2,805,173	$ -	$ 5,027,901,464
Total Operating Revenue	**4,566,766,941**	**406,152,504**	**(2,497,650)**	**54,674,495**	**2,805,173**	**-**	**5,027,901,464**
MEDICAL EXPENSES							
Provider Capitation	1,370,782,567	168,510,220	(1,407,279)				1,537,885,508
Claims	1,586,045,458	74,500,922	(184,151)	20,211,637			1,680,573,866
MLTSS	595,758,700			280,493	476,126		596,515,319
Prescription Drugs		108,677,633		6,982,244			115,659,877
Case Mgmt & Other Medical	543,793,197	22,169,964		15,896,276	2,261,236		584,120,673
Total Medical Expenses	**4,096,379,922**	**373,858,739**	**(1,591,430)**	**43,370,650**	**2,737,362**	**-**	**4,514,755,243**
Medical Loss Ratio	*89.7%*	*92.0%*	*0.0%*	*79.3%*	*97.6%*	*0.0%*	*89.8%*
GROSS MARGIN	**470,387,019**	**32,293,765**	**(906,220)**	**11,303,846**	**67,811**	**-**	**513,146,220**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	139,228,904	12,515,138		2,072,391	1,238,332		155,054,765
Non-Salary Operating Expenses	44,482,238	7,888,623		1,123,934	17,054	1,647,163	55,159,012
Depreciation & Amortization	9,578,774			11,691			9,590,465
Other Operating Expenses	35,715,219	998,043		94,095	96,238		36,903,595
Indirect Cost Allocation, Occupancy	(7,434,996)	11,772,975		201,044	82,639		4,621,662
Total Administrative Expenses	**221,570,139**	**33,174,780**	**-**	**3,503,156**	**1,434,263**	**1,647,163**	**261,329,500**
Administrative Loss Ratio	*4.9%*	*8.2%*	*0.0%*	*6.4%*	*51.1%*	*0.0%*	*5.2%*
Operating Income/(Loss)	**248,816,880**	**(881,015)**	**(906,220)**	**7,800,689**	**(1,366,452)**	**(1,647,163)**	**251,816,720**
Investments and Other Non-Operating	(82,565,688)						103,684,806
CHANGE IN NET ASSETS	**$ 166,251,192**	**$ (881,015)**	**$ (906,220)**	**$ 7,800,689**	**$ (1,366,452)**	**$ (1,647,163)**	**$ 355,501,527**
BUDGETED CHANGE IN NET ASSETS	(242,508,008)	(12,700,621)	-	(939,556)	(1,358,546)	(5,500,001)	(198,469,080)
Variance to Budget - Fav/(Unfav)	$ 408,759,200	$ 11,819,606	$ (906,220)	$ 8,740,245	$ (7,906)	$ 3,852,838	$ 553,970,606

Back to Agenda

CalOptima Health

Highlights – Consolidated, for Twelve Months Ending June 30, 2025

MONTH TO DATE RESULTS:

- Change in Net Assets is $71.5 million, favorable to budget $84.8 million
- Operating surplus is $134.6 million, with a deficit in non-operating income of $63.2 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $355.5 million, favorable to budget $554.0 million
- Operating surplus is $251.8 million, with a surplus in non-operating income of $103.7 million

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

June 2025				July 2024 - June 2025		
Actual	Budget	Variance	Operating Income (Loss)	Actual	Budget	Variance
136.0	(16.6)	152.7	Medi-Cal	248.8	(242.5)	491.3
(1.0)	(1.0)	0.0	OneCare	(0.9)	(12.7)	11.8
0.1	0.0	0.1	PACE	7.8	(0.9)	8.7
(0.1)	(0.1)	0.0	MSSP	(1.4)	(1.4)	0.0
0.7	0.0	0.7	OCC	(0.9)	0.0	(0.9)
(1.0)	(0.9)	(0.1)	Covered CA	(1.6)	(5.5)	3.9
134.6	**(18.7)**	**153.3**	**Total Operating Income (Loss)**	**251.8**	**(263.0)**	**514.8**
			Non-Operating Income (Loss)			
19.9	6.7	13.2	Net Investment Income/Expense	195.8	80.0	115.8
(0.1)	0.0	(0.1)	Other Income/Expense	(0.1)	0.0	(0.1)
(63.2)	**5.4**	**(68.5)**	**Total Non-Operating Income/(Loss)**	**103.7**	**64.5**	**39.1**
71.5	**(13.3)**	**84.8**	**TOTAL**	**355.5**	**(198.5)**	**554.0**

CalOptima Health - Consolidated
Enrollment Summary
For the Twelve Months Ending June 30, 2025

June 2025					July 2024 - June 2025			
Actual	**Budget**	**$ Variance**	**%Variance**	**Enrollment (by Aid Category)**	**Actual**	**Budget**	**$ Variance**	**%Variance**
151,802	139,325	12,477	9.0%	SPD	1,770,805	1,652,037	118,768	7.2%
258,690	272,166	(13,476)	(5.0%)	TANF Child	3,184,076	3,266,672	(82,596)	(2.5%)
128,652	138,593	(9,941)	(7.2%)	TANF Adult	1,565,536	1,657,817	(92,281)	(5.6%)
2,584	2,595	(11)	(0.4%)	LTC	30,071	31,227	(1,156)	(3.7%)
335,333	322,818	12,515	3.9%	MCE	4,048,069	3,876,389	171,680	4.4%
8,973	9,543	(570)	(6.0%)	WCM	113,007	114,625	(1,618)	(1.4%)
886,034	**885,040**	**994**	**0.1%**	**Medi-Cal Total**	**10,711,564**	**10,598,767**	**112,797**	**1.1%**
17,664	**17,586**	**78**	**0.4%**	**OneCare**	**207,356**	**209,408**	**(2,052)**	**(1.0%)**
515	**494**	**21**	**4.3%**	**PACE**	**6,066**	**5,775**	**291**	**5.0%**
539	**568**	**(29)**	**(5.1%)**	**MSSP**	**6,213**	**6,816**	**(603)**	**(8.8%)**
904,213	**903,120**	**1,093**	**0.1%**	**CalOptima Health Total**	**10,924,986**	**10,813,950**	**111,036**	**1.0%**
				Enrollment (by Network)				
345,541	302,726	42,815	14.1%	HMO	3,992,362	3,636,360	356,002	9.8%
166,912	178,922	(12,010)	(6.7%)	PHC	2,067,330	2,145,768	(78,438)	(3.7%)
67,721	132,615	(64,894)	(48.9%)	Shared Risk Group	1,116,233	1,594,915	(478,682)	(30.0%)
305,860	270,777	35,083	13.0%	Fee for Service	3,535,639	3,221,724	313,915	9.7%
886,034	**885,040**	**994**	**0.1%**	**Medi-Cal Total**	**10,711,564**	**10,598,767**	**112,797**	**1.1%**
17,664	**17,586**	**78**	**0**	**OneCare**	**207,356**	**209,408**	**(2,052)**	**(0)**
515	**494**	**21**	**4.3%**	**PACE**	**6,066**	**5,775**	**291**	**5.0%**
539	**568**	**(29)**	**(5.1%)**	**MSSP**	**6,213**	**6,816**	**(603)**	**(8.8%)**
904,213	**903,120**	**1,093**	**0.1%**	**CalOptima Health Total**	**10,924,986**	**10,813,950**	**111,036**	**1.0%**

Note: Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2025

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD Actual	YTD Budget	Variance
HMOs															
SPD	17,150	16,511	16,610	16,774	20,293	20,211	20,247	20,491	20,500	20,675	20,674	20,498	230,634	197,531	33,103
TANF Child	66,405	65,921	65,198	64,503	77,875	77,766	77,607	76,962	75,128	74,225	73,953	73,481	869,024	829,163	39,861
TANF Adult	54,590	55,734	55,056	54,535	70,864	70,611	70,439	69,398	68,589	68,129	67,874	67,422	773,241	755,706	17,535
LTC	2				1		3	2					8		8
MCE	153,578	153,602	152,129	151,153	190,284	189,645	189,821	187,512	185,344	184,148	183,128	182,709	2,103,053	1,837,376	265,677
WCM	1,241	1,234	1,214	1,163	1,370	1,479	1,514	1,430	1,429	1,412	1,485	1,431	16,402	16,584	(182)
Total	292,966	293,002	290,207	288,128	360,687	359,712	359,631	355,795	350,990	348,589	347,114	345,541	3,992,362	3,636,360	**356,002**
PHCs															
SPD	4,906	4,644	4,820	4,796	4,736	4,780	4,737	4,799	4,812	4,820	4,970	4,907	57,727	54,128	3,599
TANF Child	140,053	138,903	137,874	136,823	136,101	135,163	133,694	132,827	131,272	130,720	130,991	130,397	1,614,818	1,693,714	(78,896)
TANF Adult	3,994	4,186	4,191	4,104	4,165	4,170	4,132	4,089	4,023	4,021	3,998	3,973	49,046	61,072	(12,026)
LTC													0		0
MCE	22,999	22,762	22,600	22,551	22,507	22,511	22,520	22,277	21,942	21,838	21,725	21,604	267,836	259,797	8,039
WCM	6,571	7,308	6,733	6,550	6,336	6,573	6,580	6,496	6,433	6,206	6,086	6,031	77,903	77,057	846
Total	178,523	177,803	176,218	174,824	173,845	173,197	171,663	170,488	168,482	167,605	167,770	166,912	2,067,330	2,145,768	**(78,438)**
Shared Risk Groups															
SPD	7,270	7,077	7,057	7,133	3,422	3,411	3,353	3,413	3,321	3,422	3,522	3,483	55,884	77,885	(22,001)
TANF Child	32,783	32,842	32,545	32,325	18,564	18,412	18,308	18,287	18,168	18,156	18,653	18,386	277,429	376,254	(98,825)
TANF Adult	27,519	29,041	28,870	28,586	11,818	11,756	11,734	11,438	11,353	11,227	11,540	11,468	206,350	348,410	(142,060)
LTC				1									1	12	(11)
MCE	74,704	74,918	74,517	74,138	34,102	34,260	34,467	34,469	34,145	33,995	34,311	34,072	572,098	783,484	(211,386)
WCM	702	701	716	707	91	362	367	254	149	17	93	312	4,471	8,870	(4,399)
Total	**142,978**	**144,579**	**143,705**	**142,890**	**67,997**	**68,201**	**68,229**	**67,861**	**67,136**	**66,817**	**68,119**	**67,721**	**1,116,233**	**1,594,915**	**(478,682)**
Fee for Service (Dual)															
SPD	100,293	99,792	100,297	100,986	101,924	102,883	104,042	104,622	105,388	106,033	107,813	107,385	1,241,458	1,144,039	97,419
TANF Child													0	14	(14)
TANF Adult	1,145	1,159	1,123	1,052	1,035	1,056	1,037	1,011	937	930	899	881	12,265	22,128	(9,863)
LTC	2,178	2,203	2,209	2,222	2,208	2,237	2,234	2,204	2,216	2,218	2,328	2,291	26,748	28,003	(1,255)
MCE	4,008	4,703	4,593	4,431	4,388	4,283	4,088	3,863	3,645	3,457	3,380	3,216	48,055	109,759	(61,704)
WCM	6	7	8	15	12	12	13	13	12	15	24	18	155	108	47
Total	**107,630**	**107,864**	**108,230**	**108,706**	**109,567**	**110,471**	**111,414**	**111,713**	**112,198**	**112,653**	**114,444**	**113,791**	**1,328,681**	**1,304,051**	**24,630**
Fee for Service (Non-Dual - Total)															
SPD	15,636	15,436	15,868	15,819	15,925	16,332	14,857	15,132	15,249	15,051	14,268	15,529	185,102	178,454	6,648
TANF Child	32,741	33,377	33,868	33,995	34,269	36,369	36,010	36,850	36,407	35,994	36,499	36,426	422,805	367,527	55,278
TANF Adult	40,618	42,145	42,625	42,860	43,229	44,456	44,366	45,308	44,776	44,602	44,741	44,908	524,634	470,501	54,133
LTC	278	254	271	278	285	295	270	289	262	283	256	293	3,314	3,212	102
MCE	80,536	82,491	83,546	83,778	84,679	89,895	89,750	92,778	91,844	91,414	92,584	93,732	1,057,027	885,973	171,054
WCM	1,205	1,184	1,178	1,114	1,177	1,198	1,369	1,246	1,143	1,046	1,035	1,181	14,076	12,006	2,070
Total	**171,014**	**174,887**	**177,356**	**177,844**	**179,564**	**188,545**	**186,622**	**191,603**	**189,681**	**188,390**	**189,383**	**192,069**	**2,206,958**	**1,917,673**	**289,285**
Grand Totals															
SPD	145,255	143,460	144,652	145,508	146,300	147,617	147,236	148,457	149,270	150,001	151,247	151,802	1,770,805	1,652,037	118,768
TANF Child	271,982	271,043	269,485	267,646	266,809	267,710	265,619	264,926	260,975	259,095	260,096	258,690	3,184,076	3,266,672	(82,596)
TANF Adult	127,866	132,265	131,865	131,137	131,111	132,049	131,708	131,244	129,678	128,909	129,052	128,652	1,565,536	1,657,817	(92,281)
LTC	2,458	2,457	2,480	2,501	2,494	2,532	2,507	2,495	2,478	2,501	2,584	2,584	30,071	31,227	(1,156)
MCE	335,825	338,476	337,385	336,051	335,960	340,594	340,646	340,899	336,920	334,852	335,128	335,333	4,048,069	3,876,389	171,680
WCM	9,725	10,434	9,849	9,549	8,986	9,624	9,843	9,439	9,166	8,696	8,723	8,973	113,007	114,625	(1,618)
Total MediCal MM	**893,111**	**898,135**	**895,716**	**892,392**	**891,660**	**900,126**	**897,559**	**897,460**	**888,487**	**884,054**	**886,830**	**886,034**	**10,711,564**	**10,598,767**	**112,797**
OneCare	**17,311**	**17,307**	**17,282**	**17,173**	**17,156**	**17,037**	**17,090**	**17,238**	**17,283**	**17,339**	**17,476**	**17,664**	**207,356**	**209,408**	**(2,052)**
PACE	**506**	**508**	**503**	**498**	**502**	**506**	**502**	**503**	**501**	**506**	**516**	**515**	**6,066**	**5,775**	**291**
MSSP	**473**	**480**	**487**	**506**	**524**	**519**	**533**	**538**	**532**	**538**	**544**	**539**	**6,213**	**6,816**	**(603)**
Grand Total	**910,928**	**915,950**	**913,501**	**910,063**	**909,318**	**917,669**	**915,151**	**915,201**	**906,271**	**901,899**	**904,822**	**904,213**	**10,924,986**	**10,813,950**	**111,036**

Note: Total membership does not include MSSP

Back to Agenda

ENROLLMENT– JUNE MONTH:

Overall, June enrollment was 904,213

- Favorable to budget 1,093 or 0.1%
- Decreased 609 or 0.1% from Prior Month (PM) (May 2025)
- Decreased 14,839 or 1.6% from Prior Year (PY) (June 2024)

Medi-Cal enrollment was 886,034

- Favorable to budget 994 or 0.1%
- Medi-Cal Expansion (MCE) favorable to budget 12,515
- Seniors and Persons with Disabilities (SPD) favorable to budget 12,477
- Temporary Assistance for Needy Families (TANF) unfavorable to budget 23,417
- Whole Child Model (WCM) unfavorable to budget 570
- Long-Term Care (LTC) unfavorable to budget 11
- Decreased 796 or 0.1% from PM

OneCare enrollment was 17,664

- Favorable to budget 78 or 0.4%
- Increased 188 or 1.1% from PM

PACE enrollment was 515

- Favorable to budget 21 or 4.3%
- Decreased 1 or 0.2% from PM

MSSP enrollment was 539

- Unfavorable to budget 29 or 5.1%
- Decreased 5 or 0.9% from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2025

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
886,034	**885,040**	**994**	**0.1%**	**Member Months**	**10,711,564**	**10,598,767**	**112,797**	**1.1%**
				Revenues				
345,037,926	319,818,236	25,219,690	7.9%	Medi-Cal Capitation Revenue	4,566,766,941	3,814,724,802	752,042,139	19.7%
345,037,926	**319,818,236**	**25,219,690**	**7.9%**	**Total Operating Revenue**	**4,566,766,941**	**3,814,724,802**	**752,042,139**	**19.7%**
				Medical Expenses				
116,435,779	111,483,265	(4,952,514)	(4.4%)	Provider Capitation	1,370,782,567	1,338,467,457	(32,315,110)	(2.4%)
68,116,092	65,565,575	(2,550,517)	(3.9%)	Facilities Claims	784,619,103	783,344,594	(1,274,509)	(0.2%)
65,359,765	66,358,450	998,685	1.5%	Professional Claims	801,426,355	812,831,366	11,405,011	1.4%
52,962,773	49,301,174	(3,661,599)	(7.4%)	MLTSS	595,758,700	587,275,069	(8,483,631)	(1.4%)
7,787,827	10,164,573	2,376,746	23.4%	Incentive Payments	136,122,846	151,981,295	15,858,449	10.4%
11,559,628	9,562,885	(1,996,743)	(20.9%)	Medical Management	104,871,909	110,671,779	5,799,870	5.2%
(138,606,216)	1,830,209	140,436,425	7,673.2%	Other Medical Expenses	302,798,442	21,962,498	(280,835,944)	(1,278.7%)
183,615,648	**314,266,131**	**130,650,483**	**41.6%**	**Total Medical Expenses**	**4,096,379,922**	**3,806,534,058**	**(289,845,864)**	**(7.6%)**
161,422,279	**5,552,105**	**155,870,174**	**2,807.4%**	**Gross Margin**	**470,387,019**	**8,190,744**	**462,196,275**	**5,642.9%**
				Administrative Expenses				
12,650,049	11,760,282	(889,767)	(7.6%)	Salaries, Wages & Employee Benefits	139,228,904	144,037,589	4,808,685	3.3%
3,096,859	3,221,256	124,398	3.9%	Professional Fees	16,472,661	20,620,341	4,147,680	20.1%
2,542,538	2,587,761	45,223	1.7%	Purchased Services	23,444,178	29,784,546	6,340,368	21.3%
536,344	481,805	(54,539)	(11.3%)	Printing & Postage	4,565,399	6,251,957	1,686,558	27.0%
888,649	1,026,367	137,718	13.4%	Depreciation & Amortization	9,578,774	12,316,305	2,737,531	22.2%
4,661,388	3,707,113	(954,275)	(25.7%)	Other Operating Expenses	35,715,219	44,965,184	9,249,965	20.6%
1,011,943	(606,429)	(1,618,372)	(266.9%)	Indirect Cost Allocation, Occupancy	(7,434,996)	(7,277,170)	157,826	2.2%
25,387,769	**22,178,155**	**(3,209,614)**	**(14.5%)**	**Total Administrative Expenses**	**221,570,139**	**250,698,752**	**29,128,613**	**11.6%**
				Non-Operating Income (Loss)				
-	-	-	0.0%	Net Operating Tax	5,633,875	-	5,633,875	100.0%
(88,098,111)	-	(88,098,111)	(100.0%)	Community Reinvestment	(88,098,111)	-	(88,098,111)	(100.0%)
(95,124)	-	(95,124)	(100.0%)	Other Income/Expense	(101,452)	-	(101,452)	(100.0%)
(88,193,235)	**-**	**(88,193,235)**	**(100.0%)**	**Total Non-Operating Income (Loss)**	**(82,565,688)**	**-**	**(82,565,688)**	**(100.0%)**
47,841,274	**(16,626,050)**	**64,467,324**	**387.7%**	**Change in Net Assets**	**166,251,192**	**(242,508,008)**	**408,759,200**	**168.6%**
53.2%	***98.3%***	***(45.0%)***		***Medical Loss Ratio***	***89.7%***	***99.8%***	***(10.1%)***	
7.4%	***6.9%***	***(0.4%)***		***Admin Loss Ratio***	***4.9%***	***6.6%***	***1.7%***	

Back to Agenda

MEDI-CAL INCOME STATEMENT– JUNE MONTH:

REVENUES are $345.0 million, favorable to budget $25.2 million:

- Favorable volume variance of $0.4 million
- Favorable price related variance of $24.9 million
  - $38.3 million due to favorable member mix and draft Calendar Year (CY) 2025 capitation rates from the Department of Health Care Services (DHCS)
  - Offset by:
    - $9.8 million due to prior period revenue
    - $4.2 million from Proposition 56, Enhanced Care Management (ECM) and Unsatisfactory Immigration Status (UIS) risk corridors

MEDICAL EXPENSES are $183.6 million, favorable to budget $130.7 million:

- Unfavorable volume variance of $0.4 million
- Favorable price related variance of $131.0 million:
  - Other Medical Expenses favorable variance of $140.4 million due to change in estimates for Community Reinvestment based on updated guidance from DHCS and recategorization to Non-Operating Expenses
  - Incentive Payments expense favorable variance of $2.4 million
  - Professional Claims expense favorable variance of $1.1 million
  - Offset by:
    - Provider Capitation expense unfavorable variance of $4.8 million
    - Managed Long-Term Services and Supports (MLTSS) expense unfavorable variance of $3.6 million
    - Facilities Claims expense unfavorable variance of $2.5 million
    - Medical Management expense unfavorable variance of $2.0 million

ADMINISTRATIVE EXPENSES are $25.4 million, unfavorable to budget $3.2 million:

- Non-Salary expense unfavorable to budget $2.3 million
- Salaries, Wages & Employee Benefits expense unfavorable to budget $0.9 million

CHANGE IN NET ASSETS is $47.8 million, favorable to budget $64.5 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
17,664	**17,586**	**78**	**0.4%**	**Member Months**	**207,356**	**209,408**	**(2,052)**	**(1.0%)**
				Revenues				
23,597,413	26,478,812	(2,881,399)	(10.9%)	Medicare Part C Revenue	286,721,742	313,306,872	(26,585,130)	(8.5%)
9,546,415	9,550,613	(4,198)	(0.0%)	Medicare Part D Revenue	119,430,762	113,338,105	6,092,657	5.4%
33,143,828	**36,029,425**	**(2,885,598)**	**(8.0%)**	**Total Operating Revenue**	**406,152,504**	**426,644,977**	**(20,492,473)**	**(4.8%)**
				Medical Expenses				
13,973,584	16,164,158	2,190,574	13.6%	Provider Capitation	168,510,220	191,288,447	22,778,227	11.9%
4,660,690	4,999,721	339,031	6.8%	Inpatient	50,968,008	58,750,433	7,782,425	13.2%
2,233,712	1,747,608	(486,104)	(27.8%)	Ancillary	23,532,914	20,855,007	(2,677,907)	(12.8%)
9,247,351	9,023,385	(223,966)	(2.5%)	Prescription Drugs	108,677,633	107,296,579	(1,381,054)	(1.3%)
569,260	470,583	(98,677)	(21.0%)	Incentive Payments	7,084,916	5,860,253	(1,224,663)	(20.9%)
1,329,913	1,412,303	82,390	5.8%	Medical Management	12,386,569	16,682,090	4,295,521	25.7%
366,744	-	(366,744)	(100.0%)	Other Medical Expenses	2,698,479	-	(2,698,479)	(100.0%)
32,381,253	**33,817,758**	**1,436,505**	**4.2%**	**Total Medical Expenses**	**373,858,739**	**400,732,809**	**26,874,070**	**6.7%**
762,574	**2,211,667**	**(1,449,093)**	**(65.5%)**	**Gross Margin**	**32,293,765**	**25,912,168**	**6,381,597**	**24.6%**
				Administrative Expenses				
741,712	1,188,377	446,665	37.6%	Salaries, Wages & Employee Benefits	12,515,138	14,521,947	2,006,809	13.8%
95,219	142,037	46,818	33.0%	Professional Fees	1,057,560	1,521,750	464,190	30.5%
779,258	555,024	(224,234)	(40.4%)	Purchased Services	4,964,510	6,130,404	1,165,894	19.0%
385,416	164,958	(220,458)	(133.6%)	Printing & Postage	1,866,553	2,648,408	781,855	29.5%
66,042	138,936	72,894	52.5%	Other Operating Expenses	998,043	1,477,280	479,237	32.4%
(332,499)	1,026,087	1,358,586	132.4%	Indirect Cost Allocation, Occupancy	11,772,975	12,313,000	540,025	4.4%
1,735,149	**3,215,419**	**1,480,270**	**46.0%**	**Total Administrative Expenses**	**33,174,780**	**38,612,789**	**5,438,009**	**14.1%**
(972,574)	**(1,003,752)**	**31,178**	**3.1%**	**Change in Net Assets**	**(881,015)**	**(12,700,621)**	**11,819,606**	**93.1%**
97.7%	***93.9%***	***3.8%***		***Medical Loss Ratio***	***92.0%***	***93.9%***	***(1.9%)***	
5.2%	***8.9%***	***3.7%***		***Admin Loss Ratio***	***8.2%***	***9.1%***	***0.9%***	

Back to Agenda

ONECARE INCOME STATEMENT – JUNE MONTH:

REVENUES are $33.1 million, unfavorable to budget $2.9 million:

- Favorable volume related variance of $0.2 million
- Unfavorable price related variance of $3.0 million driven by PY risk adjustment estimates

MEDICAL EXPENSES are $32.4 million, favorable to budget $1.4 million:

- Unfavorable volume related variance of $0.1 million
- Favorable price related variance of $1.6 million

ADMINISTRATIVE EXPENSES are $1.7 million, favorable to budget $1.5 million

- Non-Salary expense favorable to budget $1.0 million
- Salaries, Wages & Employee Benefits expense favorable to budget $0.4 million

CHANGE IN NET ASSETS is ($1.0) million, favorable to budget $31,178

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
515	**494**	**21**	**4.3%**	**Member Months**	**6,066**	**5,775**	**291**	**5.0%**
				Revenues				
3,526,525	3,105,687	420,838	13.6%	Medi-Cal Capitation Revenue	40,281,286	36,266,198	4,015,088	11.1%
956,939	784,860	172,079	21.9%	Medicare Part C Revenue	10,310,764	9,032,904	1,277,860	14.1%
459,797	249,338	210,459	84.4%	Medicare Part D Revenue	4,082,445	2,909,452	1,172,993	40.3%
4,943,262	**4,139,885**	**803,377**	**19.4%**	**Total Operating Revenue**	**54,674,495**	**48,208,554**	**6,465,941**	**13.4%**
				Medical Expenses				
1,873,208	1,348,184	(525,024)	(38.9%)	Medical Management	15,896,276	16,388,393	492,117	3.0%
799,837	769,136	(30,701)	(4.0%)	Facilities Claims	8,562,189	9,015,372	453,183	5.0%
919,303	853,269	(66,034)	(7.7%)	Professional Claims	8,661,097	9,963,993	1,302,896	13.1%
549,540	578,242	28,702	5.0%	Prescription Drugs	6,982,244	6,676,308	(305,936)	(4.6%)
64,300	49,851	(14,449)	(29.0%)	MLTSS	280,493	413,957	133,464	32.2%
292,417	260,446	(31,971)	(12.3%)	Patient Transportation	2,988,351	3,125,361	137,010	4.4%
4,498,604	**3,859,128**	**(639,476)**	**(16.6%)**	**Total Medical Expenses**	**43,370,650**	**45,583,384**	**2,212,734**	**4.9%**
444,658	**280,757**	**163,901**	**58.4%**	**Gross Margin**	**11,303,846**	**2,625,170**	**8,678,676**	**330.6%**
				Administrative Expenses				
190,171	169,185	(20,986)	(12.4%)	Salaries, Wages & Employee Benefits	2,072,391	2,072,865	474	0.0%
23,260	8,712	(14,548)	(167.0%)	Professional Fees	103,437	104,800	1,363	1.3%
141,564	72,478	(69,086)	(95.3%)	Purchased Services	860,017	814,105	(45,912)	(5.6%)
24,211	7,030	(17,181)	(244.4%)	Printing & Postage	160,480	188,950	28,470	15.1%
980	1,600	620	38.7%	Depreciation & Amortization	11,691	19,200	7,509	39.1%
(5,932)	17,737	23,669	133.4%	Other Operating Expenses	94,095	163,706	69,611	42.5%
8,091	17,062	8,971	52.6%	Indirect Cost Allocation, Occupancy	201,044	201,100	56	0.0%
382,347	**293,804**	**(88,543)**	**(30.1%)**	**Total Administrative Expenses**	**3,503,156**	**3,564,726**	**61,570**	**1.7%**
62,311	**(13,047)**	**75,358**	**577.6%**	**Change in Net Assets**	**7,800,689**	**(939,556)**	**8,740,245**	**930.3%**
91.0%	***93.2%***	***(2.2%)***		***Medical Loss Ratio***	***79.3%***	***94.6%***	***(15.2%)***	
7.7%	***7.1%***	***(0.6%)***		***Admin Loss Ratio***	***6.4%***	***7.4%***	***1.0%***	

Back to Agenda

CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
539	**568**	**(29)**	**(5.1%)**	**Member Months**	**6,213**	**6,816**	**(603)**	**(8.8%)**
				Revenues				
206,109	253,521	(47,412)	(18.7%)	Revenue	2,805,173	3,042,208	(237,035)	(7.8%)
206,109	**253,521**	**(47,412)**	**(18.7%)**	**Total Operating Revenue**	**2,805,173**	**3,042,208**	**(237,035)**	**(7.8%)**
				Medical Expenses				
192,260	207,787	15,527	7.5%	Medical Management	2,261,236	2,493,411	232,175	9.3%
42,782	32,960	(9,822)	(29.8%)	Waiver Services	476,126	395,487	(80,639)	(20.4%)
192,260	207,787	15,527	7.5%	Total Medical Management	2,261,236	2,493,411	232,175	9.3%
42,782	32,960	(9,822)	(29.8%)	Total Waiver Services	476,126	395,487	(80,639)	(20.4%)
235,042	**240,747**	**5,705**	**2.4%**	**Total Program Expenses**	**2,737,362**	**2,888,898**	**151,536**	**5.2%**
(28,933)	**12,774**	**(41,707)**	**(326.5%)**	**Gross Margin**	**67,811**	**153,310**	**(85,499)**	**(55.8%)**
				Administrative Expenses				
106,417	107,023	606	0.6%	Salaries, Wages & Employee Benefits	1,238,332	1,307,856	69,524	5.3%
1,417	1,413	(4)	(0.3%)	Professional Fees	17,000	17,000	-	0.0%
6	-	(6)	(100.0%)	Purchased Services	54	-	(54)	(100.0%)
11,376	8,250	(3,126)	(37.9%)	Other Operating Expenses	96,238	99,000	2,762	2.8%
1,695	7,337	5,642	76.9%	Indirect Cost Allocation, Occupancy	82,639	88,000	5,361	6.1%
120,911	**124,023**	**3,112**	**2.5%**	**Total Administrative Expenses**	**1,434,263**	**1,511,856**	**77,593**	**5.1%**
(149,845)	**(111,249)**	**(38,596)**	**(34.7%)**	**Change in Net Assets**	**(1,366,452)**	**(1,358,546)**	**(7,906)**	**(0.6%)**
114.0%	***95.0%***	***19.1%***		***Medical Loss Ratio***	***97.6%***	***95.0%***	***2.6%***	
58.7%	***48.9%***	***(9.7%)***		***Admin Loss Ratio***	***51.1%***	***49.7%***	***(1.4%)***	

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Twelve Months Ending June 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
-	**-**	**-**	**0.0%**	**Member Months**	**-**	**-**	**-**	**0.0%**
				Revenues				
699,715	-	699,715	100.0%	Medicare Part C Revenue	(2,497,650)	-	(2,497,650)	(100.0%)
699,715	**-**	**699,715**	**100.0%**	**Total Operating Revenue**	**(2,497,650)**	**-**	**(2,497,650)**	**(100.0%)**
				Medical Expenses				
45,758	-	(45,758)	(100.0%)	Provider Capitation	(1,407,279)	-	1,407,279	100.0%
-	-	-	0.0%	Facilities Claims	(184,151)	-	184,151	100.0%
45,758	**-**	**(45,758)**	**(100.0%)**	**Total Medical Expenses**	**(1,591,430)**	**-**	**1,591,430**	**100.0%**
653,957	**-**	**653,957**	**100.0%**	**Gross Margin**	**(906,220)**	**-**	**(906,220)**	**(100.0%)**
				Administrative Expenses				
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
653,957	**-**	**653,957**	**100.0%**	**Change in Net Assets**	**(906,220)**	**-**	**(906,220)**	**(100.0%)**
6.5%	***0.0%***	***6.5%***		***Medical Loss Ratio***	***63.7%***	***0.0%***	***63.7%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	

Back to Agenda

CalOptima Health
Covered CA
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2025

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
-	-	-	0.0%	**Member Months**	-	-	-	0.0%
				Revenues				
-	-	-	0.0%	Medi-Cal Capitation Revenue	-	-	-	0.0%
-	-	-	0.0%	**Total Operating Revenue**	-	-	-	0.0%
				Medical Expenses				
-	-	-	0.0%	**Total Medical Expenses**	-	-	-	0.0%
-	-	-	0.0%	**Gross Margin**	-	-	-	0.0%
				Administrative Expenses				
982,129	916,671	(65,458)	(7.1%)	Professional Fees	1,647,163	5,500,001	3,852,838	70.1%
982,129	**916,671**	**(65,458)**	**(7.1%)**	**Total Administrative Expenses**	**1,647,163**	**5,500,001**	**3,852,838**	**70.1%**
				Non-Operating Income (Loss)				
-	-	-	0.0%	Net Operating Tax	-	-	-	0.0%
-	-	-	0.0%	Net QAF & IGT Income/Expense	-	-	-	0.0%
-	-	-	0.0%	Other Income/Expense	-	-	-	0.0%
-	-	-	0.0%	**Total Non-Operating Income (Loss)**	-	-	-	0.0%
(982,129)	**(916,671)**	**(65,458)**	**(7.1%)**	**Change in Net Assets**	**(1,647,163)**	**(5,500,001)**	**3,852,838**	**70.1%**
0.0%	***0.0%***	***0.0%***		***Medical Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	

Back to Agenda

CalOptima Health
Building - 505 City Parkway
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
62,237	22,903	(39,334)	(171.7%)	Purchased Services	642,531	274,858	(367,673)	(133.8%)
181,054	195,000	13,946	7.2%	Depreciation & Amortization	2,171,997	2,340,000	168,003	7.2%
23,371	26,655	3,284	12.3%	Insurance Expense	292,900	319,849	26,949	8.4%
177,232	181,190	3,958	2.2%	Repair & Maintenance	1,521,809	2,174,236	652,427	30.0%
54,676	56,823	2,147	3.8%	Other Operating Expenses	670,053	681,887	11,834	1.7%
(498,570)	(482,571)	15,999	3.3%	Indirect Cost Allocation, Occupancy	(5,299,290)	(5,790,830)	(491,540)	(8.5%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

CalOptima Health
Building - 500 City Parkway
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
130,891	135,865	(4,974)	(4%)	Rental Income	1,904,972	1,630,391	274,581	16.8%
130,891	**135,865**	**(4,974)**	**(3.7%)**	**Total Operating Revenue**	**1,904,972**	**1,630,391**	**274,581**	**16.8%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
40,788	9,325	(31,463)	(337.4%)	Purchased Services	492,887	111,955	(380,932)	(340.3%)
58,789	51,000	(7,789)	(15.3%)	Depreciation & Amortization	668,128	612,000	(56,128)	(9.2%)
8,600	8,741	141	1.6%	Insurance Expense	100,100	104,947	4,847	4.6%
91,811	94,592	2,781	2.9%	Repair & Maintenance	576,916	1,135,104	558,188	49.2%
19,414	25,975	6,562	25.3%	Other Operating Expenses	270,216	311,733	41,517	13.3%
(17,830)	-	17,830	100.0%	Indirect Cost Allocation, Occupancy	(217,862)	-	217,862	100.0%
201,571	**189,633**	**(11,938)**	**(6.3%)**	**Total Administrative Expenses**	**1,890,385**	**2,275,739**	**385,354**	**16.9%**
(70,680)	**(53,768)**	**(16,912)**	**(31.5%)**	**Change in Net Assets**	**14,587**	**(645,348)**	**659,935**	**102.3%**

Back to Agenda

CalOptima Health
Building - 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2025

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
50,624	42,500	(8,124)	(19.1%)	Purchased Services	380,457	510,000	129,543	25.4%
9,397	21,000	11,603	55.3%	Depreciation & Amortization	112,769	252,000	139,231	55.3%
4,751	-	(4,751)	(100.0%)	Insurance Expense	56,001	-	(56,001)	(100.0%)
2,498	-	(2,498)	(100.0%)	Repair & Maintenance	7,768	-	(7,768)	(100.0%)
1,263	-	(1,263)	(100.0%)	Other Operating Expenses	13,288	-	(13,288)	(100.0%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
68,533	**63,500**	**(5,033)**	**(7.9%)**	**Total Administrative Expenses**	**570,283**	**762,000**	**191,717**	**25.2%**
(68,533)	**(63,500)**	**(5,033)**	**(7.9%)**	**Change in Net Assets**	**(570,283)**	**(762,000)**	**191,717**	**25.2%**

OTHER PROGRAM INCOME STATEMENTS – JUNE MONTH:

PACE

- **CHANGE IN NET ASSETS** is $62,311, favorable to budget $75,358

MSSP

- **CHANGE IN NET ASSETS** is ($149,845), unfavorable to budget $38,596

Covered CA

- **CHANGE IN NET ASSETS** is ($1.0) million, unfavorable to budget $0.1 million

NON-OPERATING INCOME STATEMENTS – JUNE MONTH:

BUILDING 500 City Parkway

- **CHANGE IN NET ASSETS** is ($70,680), unfavorable to budget $16,912
  - Net of $130,891 in Rental Income and $201,571 in Administrative Expenses

BUILDING 7900 Garden Grove Blvd

- **CHANGE IN NET ASSETS** is ($68,533), unfavorable to budget $5,033

INVESTMENT INCOME

- Favorable variance of $13.2 million compared to budget driven by an increase in realized and unrealized gains on investments due to lower interest rates

CalOptima Health
Balance Sheet
June 30, 2025

	June-25	May-25	$ Change	% Change
ASSETS				
Current Assets				
Cash and Cash Equivalents	475,203,955	585,417,907	(110,213,952)	(18.8%)
Short-term Investments	1,340,926,601	1,306,481,200	34,445,401	2.6%
Capitation Receivable	653,537,573	595,472,115	58,065,458	9.8%
Receivables - Other	95,574,162	93,591,246	1,982,916	2.1%
Prepaid Expenses	11,183,062	14,208,216	(3,025,154)	(21.3%)
Total Current Assets	**2,576,425,353**	**2,595,170,684**	**(18,745,331)**	**(0.7%)**
Board Designated Assets				
Board Designated Reserves	1,584,426,734	1,573,812,290	10,614,444	0.7%
Statutory Designated Reserves	132,380,774	131,292,301	1,088,473	0.8%
Total Designated Assets	**1,716,807,508**	**1,705,104,591**	**11,702,917**	**0.7%**
Restricted Deposit	**300,000**	**300,000**	**-**	**0.0%**
Capital Assets, Net	**98,622,705**	**98,528,317**	**94,388**	**0.1%**
Total Assets	**4,392,155,566**	**4,399,103,592**	**(6,948,027)**	**(0.2%)**
Deferred Outflows of Resources				
Advance Discretionary Payment	-	49,999,717	(49,999,717)	(100.0%)
Net Pension	27,437,072	24,549,290	2,887,782	11.8%
Other Postemployment Benefits	1,189,000	1,350,000	(161,000)	(11.9%)
Total Deferred Outflows of Resources	**28,626,072**	**75,899,007**	**(47,272,935)**	**(62.3%)**
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	**4,420,781,638**	**4,475,002,599**	**(54,220,962)**	**(1.2%)**
LIABILITIES				
Current Liabilities				
Accounts Payable	233,986,507	169,146,029	64,840,478	38.3%
Medical Claims Liability	1,047,737,339	1,118,595,383	(70,858,043)	(6.3%)
Accrued Payroll Liabilities	29,845,788	20,192,220	9,653,568	47.8%
Deferred Revenue	22,054,562	52,706,769	(30,652,207)	(58.2%)
Other Current Liabilities	-	-	-	0.0%
Capitation & Withholds	153,993,365	147,550,408	6,442,957	4.4%
Total Current Liabilities	**1,487,617,562**	**1,508,190,809**	**(20,573,247)**	**(1.4%)**
GASB 96 Subscription Liabilities	16,837,359	17,058,702	(221,344)	(1.3%)
Community Reinvestment	88,098,111	148,058,180	(59,960,069)	(40.5%)
Capital Lease Payable	245,394	249,289	(3,895)	(1.6%)
Postemployment Health Care Plan	17,249,000	17,729,256	(480,256)	(2.7%)
Net Pension Liability	5,840,992	45,981,359	(40,140,367)	(87.3%)
Total Liabilities	**1,615,888,418**	**1,737,267,595**	**(121,379,178)**	**(7.0%)**
Deferred Inflows of Resources				
Net Pension	1,321,519	2,248,445	(926,926)	(41.2%)
Other Postemployment Benefits	2,988,000	6,398,000	(3,410,000)	(53.3%)
Total Deferred Inflows of Resources	**4,309,519**	**8,646,445**	**(4,336,926)**	**(50.2%)**
Net Position				
Required TNE	129,341,855	129,014,190	327,665	0.3%
Funds in excess of TNE	2,671,241,846	2,600,074,369	71,167,477	2.7%
Total Net Position	**2,800,583,701**	**2,729,088,559**	**71,495,142**	**2.6%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION	**4,420,781,638**	**4,475,002,599**	**(54,220,962)**	**(1.2%)**

Back to Agenda

BALANCE SHEET – JUNE MONTH:

ASSETS of $4.4 billion decreased $54.2 million from May or 1.2%

- Operating Cash and Short-Term Investments decreased $75.8 million due to DHCS recoupments of $56.5 million for CY 2023 capitation and $45.7 million for Prop 56, offset by increases of $9.5 million for Short-Term Investment income and $8.6 million for pharmacy rebates
- Deferred Outflows decreased $47.3 million due to the annual true-up to actuarial reports for the CalPERS pension for CalOptima Health employees
- Capitation Receivables increased $58.1 million primarily due to one month of Managed Care Organization (MCO) tax revenue from DHCS
- Total Designated Assets increased $11.7 million due to $6.3 million of investment income and $5.3 million of unrealized gain due to a decrease in long term interest rates

LIABILITIES of $1.6 billion decreased $121.4 million from May or 7.0%

- Medical Claims Liability decreased $70.9 million due to the payout of $106.6 million of Hospital Quality Assurance Fee Program (HQAF) directed payments, offset by current month Incurred But Not Received (IBNR) accrual activity
- Community Reinvestment liabilities decreased $60.0 million due to a calculation true-up related to COVID-19 expenses
- Net Pension Liabilities decreased $40.1 million related to the annual true-up to actuarial reports for the CalPERS pension for CalOptima Health employees
- Deferred Revenue decreased $30.7 million due to the June OneCare (OC) Centers for Medicare & Medicaid Services (CMS) capitation received and recognized in May
- Accounts Payable increased $64.8 million primarily due to the MCO tax accrual
- Accrued Payroll Liabilities increased $9.7 million due to the variability in the number of days in the month and the pay period timing
- Capitation and Withholds increased $6.4 million due to Healthcare Effectiveness Data and Information Set (HEDIS) and quality accruals

NET ASSETS of $2.8 billion, increased $71.5 million from May or 2.6%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of June 30, 2025

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	792,253,537				
MetLife Tier One	792,173,197				
Board Designated Reserves	1,584,426,734	1,044,702,453	1,671,523,924	539,724,282	(87,097,190)
Current Reserve Level (X months of average monthly revenue) [1]	*3.79*	*2.50*	*4.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	66,314,587				
MetLife Tier Two	66,066,187				
Statutory Designated Reserves	132,380,774	129,341,855	142,276,041	3,038,918	(9,895,267)
Current Reserve Level (X min. TNE) [1]	*1.02*	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

CalOptima Health
Statement of Cash Flow
June 30, 2025

	June 2025	July 2024 - June 2025
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	71,495,142	355,501,527
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation & Amortization	1,138,869	12,543,360
Changes in assets and liabilities:		
Prepaid expenses and other	3,025,154	(13,943)
Capitation receivable	(60,048,374)	(194,425,251)
Medical claims liability	(70,858,043)	(104,106,785)
Deferred revenue	(30,652,207)	6,793,399
Payable to health networks	6,442,957	(22,240,329)
Accounts payable	64,840,478	61,666,901
Accrued payroll	(30,967,054)	(36,302,247)
Other accrued liabilities	(60,185,308)	(18,468,014)
Net cash provided by/(used in) operating activities	(105,768,387)	60,948,617
GASB 68, GASB 75 and Advance Discretionary Payment Adjustments	42,936,009	42,936,009
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	(34,445,401)	436,969,339
Change in Property and Equipment	(1,233,256)	(14,605,257)
Change in Restricted Deposit & Other	-	-
Change in Board Designated Reserve	(11,702,917)	(579,044,070)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	(47,381,574)	(156,679,988)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	(110,213,952)	(52,795,362)
CASH AND CASH EQUIVALENTS, beginning of period	585,417,907	527,999,317
CASH AND CASH EQUIVALENTS, end of period	**475,203,955**	**475,203,955**

CalOptima Health
Spending Plan
For the Twelve Months Ending June 30, 2025

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 6/30/2025	**$2,800.6**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,584.4**			**56.6%**
	Statutory Designated Reserve[1]	**$132.4**			**4.7%**
	Capital Assets, net of Depreciation	**$98.6**			**3.5%**
Resources Allocated[3]	Homeless Health Initiative[2]	$20.8	$65.9	$45.1	0.7%
	Housing and Homelessness Incentive Program[2]	25.8	87.4	61.5	0.9%
	Intergovernmental Transfers (IGT)[4]	45.1	52.1	6.9	1.6%
	Digital Transformation and Workplace Modernization[3]	29.2	100.0	70.8	1.0%
	CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
	CalFresh and Redetermination Outreach Strategy	1.7	6.0	4.3	0.1%
	Coalition of Orange County Community Health Centers Grant	25.7	50.0	24.3	0.9%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	General Awareness Campaign	0.4	4.7	4.3	0.0%
	Member Health Needs Assessment	0.6	1.3	0.7	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	120.3	153.5	33.2	4.3%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.4%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program Grant	3.0	5.0	2.0	0.1%
	Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program Grant	1.5	2.7	1.2	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	44.5	50.0	5.5	1.6%
	Distribution Event - Naloxone Grant	2.2	15.0	12.8	0.1%
	Garden Grove Bldg. Improvement	9.8	10.5	0.7	0.4%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.4%
	Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
	Outreach Strategy for newly eligible Adult Expansion members	3.2	7.6	4.3	0.1%
	Quality Initiatives from unearned Pay for Value Program	18.8	23.3	4.5	0.7%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.3	1.2	0.9	0.0%
	Medi-Cal Provider Rate Increases	315.7	526.2	210.5	11.3%
	Homeless Prevention and Stabilization Pilot Program	0.2	0.3	0.0	0.0%
	OneCare Member Engagement and Education	0.3	0.3	0.0	0.0%
	Subtotal:	**$720.2**	**$1,236.7**	**$516.5**	**25.7%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$265.0**			**9.5%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 168 days of CalOptima Health's current operations.
[2] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.
[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.
[4] On June 5, 2025, the Board of Directors approved the close out of Board-approved initiatives and transfer of remaining funds back to unallocated reserves.

Back to Agenda

CalOptima Health
Key Financial Indicators
As of June 30, 2025

	Item Name	June 2025 Actual	June 2025 Budget	June 2025 Variance	June 2025 %		July 2024 - June 2025 Actual	July 2024 - June 2025 Budget	July 2024 - June 2025 Variance	July 2024 - June 2025 %	
Income Statement	Member Months	904,213	903,120	1,093	0.1%		10,924,986	10,813,950	111,036	1.0%	
	Operating Revenue	384,030,839	360,241,067	23,789,772	6.6%		5,027,901,464	4,292,620,541	735,280,923	17.1%	
	Medical Expenses	220,776,305	352,183,764	131,407,459	37.3%		4,514,755,243	4,255,739,149	(259,016,094)	(6.1%)	
	General and Administrative Expense	28,608,305	26,728,072	(1,880,234)	(7.0%)		261,329,500	299,888,124	38,558,623	12.9%	
	Non-Operating Income/(Loss)	(63,151,087)	5,370,638	(68,521,725)	(1275.9%)		103,684,806	64,537,652	39,147,154	60.7%	
	Summary of Income & Expenses	71,495,142	(13,300,131)	84,795,273	637.6%		355,501,527	(198,469,080)	553,970,606	279.1%	
Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	57.5%	97.8%	(40.3%)			89.8%	99.1%	(9.3%)		
	Administrative Loss Ratio (ALR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	7.4%	7.4%	(0.0%)			5.2%	7.0%	1.8%		

Key:

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

Investment	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
	@6/30/2025	3,030,032,349	2,985,456,521	44,575,829	1.5%

Unallocated/Unassigned Reserve Balance	Current Month @ June 2025	Fiscal Year Ending June 2024	Change	%
Consolidated	264,975,684	187,643,914	77,331,770	41.2%
*Days Cash On Hand**	168			

*Total Designated Reserves and unallocated reserve amount can support approximately 168 days of CalOptima Health's current operations.

Back to Agenda

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Twelve Months Ending June 30, 2025

	June 2025				July 2024 - June 2025				All Time to Date			
	Actual Spend	Approved Budget	Variance $	Variance %	Actual Spend	Approved Budget	Variance $	Variance %	Actual Spend	Approved Budget	Variance $	Variance %
Capital Assets (Cost, Information Only):												
Total Capital Assets	**809,704**	**1,576,280**	**766,576**	**48.6%**	**7,168,091**	**7,462,000**	**293,909**	**3.9%**	**15,610,952**	**31,525,709**	**15,914,757**	**50.5%**
Operating Expenses:												
Salaries, Wages & Benefits	577,510	589,845	12,335	2.1%	6,819,791	7,078,173	258,382	3.7%	17,826,058	18,084,440	258,382	1.4%
Professional Fees	1,062,918	452,986	(609,932)	(134.6%)	5,039,748	6,321,500	1,281,752	20.3%	6,800,811	8,082,563	1,281,752	15.9%
Purchased Services	272,965	142,000	(130,965)	(92.2%)	1,182,669	1,704,000	521,331	30.6%	1,332,669	1,854,000	521,331	28.1%
GASB 96 Amortization Expenses	51,082	293,413	242,331	82.6%	591,966	3,521,000	2,929,034	83.2%	2,563,169	5,492,203	2,929,034	53.3%
Other Expenses	1,233,526	817,783	(415,743)	(50.8%)	7,566,249	8,927,662	1,361,413	15.2%	21,095,741	22,457,154	1,361,413	6.1%
Medical Management	229,257	-	(229,257)	0.0%	2,751,078	-	(2,751,078)	0.0%	5,502,156	2,751,078	(2,751,078)	(100.0%)
Total Operating Expenses	**3,427,259**	**2,296,027**	**(1,131,232)**	**(49.3%)**	**23,951,502**	**27,552,335**	**3,600,833**	**13.1%**	**55,120,606**	**58,721,438**	**3,600,833**	**6.1%**

Funding Balance Tracking:	**Approved Budget**	**Actual Spend**	**Variance**
Beginning Funding Balance	100,000,000	100,000,000	-
Less:			
Capital Assets[1]	31,525,709	15,610,952	15,914,757
FY2023 Operating Budget[2]	8,381,011	8,381,011	-
FY2024 Operating Budget	22,788,092	22,788,092	-
FY2025 Operating Budget	27,552,335	23,951,502	3,600,833
Ending Funding Balance	**9,752,853**	**29,268,443**	**19,515,590**
Add: Prior year unspent Operating Budget	-		
Total Available Funding	**9,752,853**		

[1] Staff will continue to monitor the project status of DTS' Capital Assets.
[2] Unspent budget from this period is added back to available DTS funding.
[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

Note: Report includes applicable transactions for GASB 96, Subscriptions - Based Information Technology Arrangements.

Back to Agenda

CalOptima Health
Summary of Homeless Health Initiatives (HHI) and Allocated Funds
As of June 30, 2025

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
HHI - IGT'S	59,900,000	59,831,301	45,150,696	14,680,605	68,699
HHI - Existing Reserves	6,100,000	6,100,000	-	6,100,000	-
HHIP	40,100,000	40,100,000	-	40,100,000	-
Total	**106,100,000**	**106,031,301**	**45,150,696**	**60,880,605**	**68,699**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-	IGT's
Recuperative Care	6,194,190	6,194,190	-	IGT's
Medical Respite	250,000	250,000	-	IGT's
Day Habilitation (County for HomeKey)	2,500,000	-	2,500,000	IGT's
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-	IGT's
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-	IGT's
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522	IGT's
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	925,540	37,721	IGT's
FQHC (Community Health Center) Expansion	21,902	21,902	-	IGT's
HCAP and CalOptima Health Days	9,888,914	4,334,952	5,553,961	IGT's
Vaccination Intervention and Member Incentive Strategy[1]	54,649	54,649	-	IGT's
Street Medicine[2]	14,376,652	7,593,244	6,783,408	IGT's & Existing Reserves
Outreach and Engagement	7,000,000	1,138,008	5,861,992	IGT's
Housing and Homelessness Incentive Program (HHIP)[3]	40,100,000	-	40,100,000	IGT's & Existing Reserves
Subtotal of Approved Initiatives	**106,031,301**	**45,150,696**	**60,880,604**	
Transfer of funds to HHIP[3]	(40,100,000)	-	(40,100,000)	
Program Total	**65,931,301**	**45,150,696**	**20,780,604**	

[1]On June 5, 2025 the Board of Directors approved the close out of the Vaccination Intervention and Member Incentive Strategy program and transfer of the remaining funds of $68,699 to unallocated reserves for new initiatives

[2]On March 19, 2025, CalOptima Health's Board of Directors approved $4.3 million from existing reserves to fund a new Street Medicine Program (Santa Ana). On March 7, 2024, CalOptima Health's Board of Directors approved $5.0 million to expand the Street Medicine Program. $3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and $1.8 million from existing reserves to fund 2-year agreements with Healthcare in Action (Anaheim) and Celebrating Life Community Health Center (Costa Mesa)

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

CalOptima Health
Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds
As of June 30, 2025

Summary by Funding Source:	Total Funds[1]	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	54,930,994	30,916,048	24,014,947	$18,000,195
Existing Reserves & HHI Transfer	87,384,530	87,384,530	61,543,126	25,841,404	-
Total	**160,315,719**	**142,315,524**	**92,459,174**	**49,856,351**	**18,000,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	862,350	537,650	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,621,311	1,000,001	HHI & DHCS
Infrastructure Projects	5,832,314	5,580,354	251,960	HHI
Capital Projects	108,247,369	73,195,575	35,051,794	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	6,344,193	3,840,337	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	**$133,185,524[1]**	**$92,459,173**	**$40,726,351**	

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments

CalOptima Health
Fiscal Year 2024-25 Budget Allocation Changes
Reporting Changes as of May 31, 2025

Transfer Month	Line of Business	From	To	Amount	Reason to Re-Allocate Funds
July	Medi-Cal	ITS - Applications Management - System Development Enhancement for CalAIM	ITS - Applications Management - Care Management System - ZeOmega JIVA	$249,000	For ZeOmega JIVA for reporting post Go Live
July	Medi-Cal	Accounting - Purchased Services	Accounting - Printing and Postage	$20,000	To provide additional funding for toner purchase
August	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - VMWare	ITS - Infrastructure - Other Operating Expenses - IT Service Management	$38,490	To address additional licensing needs and increased costs for the Impact Guide
August	Medi-Cal	IS - Applications Management - Professional Fees - Salesforce CRM	ITS - Applications Management - Other Operating Expenses - Crowe Subscription License Fee	$38,500	To provide funding needed for license fee
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Infrastructure - Network Bandwidth Upgrade for All Sites (Wide Area Network)	$10,349	For All Sites (Wide Area Network) due to increase in expenses
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Application Development - Digital Transformation Strategy Planning and Execution Support	$32,425	Due to increase in expenses
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Applications Management - Clinical Data Sets Quality Assurance & Data Aggregator Validation	$70,000	Due to increase in expenses
August	Medi-Cal	ITS - Application Development - Other Operating Expenses - Veracode Code Scanning	Executive Office - Other Operating Expenses - CEO Leadership Alliance of Orange County (CLAOC)	$40,000	For Veracode Code Scanning To Executive Office - CEO Leadership Alliance of Orange County (CLAOC) Associations dues
September	OneCare	Communications - Purchased Services - Advertising	Communications - Professional Fees	$144,000	To provide additional funding for Runyon Saltzman for Marketing
September	Medi-Cal	ITS - Applications Management - Other Operating Expenses - HW/SW Maintenance	Executive Office - Other Operating Expenses - Professional Dues	$50,000	For coverage of expenses
September	Medi-Cal	Accounting - Purchased Services	Accounting - Other Operating Expenses - Office Supplies	$15,000	To provide additional funding needed to replenish check stock
September	PACE	PACE Administrative - Professional Fees	PACE Administrative - Other Operating Expenses - Subscriptions	$15,000	To provide funding for DHCS PACE licensing Fees
September	Medi-Cal	ITS - Application Development - Other Operating Expenses - HW/SW Maintenance	ITS - Applications Management - Other Operating Expenses - Care Management System - HealthEdge	$158,000	To help pay for Guiding Care Read Only invoice
September	OneCare	Sales & Marketing - Purchased Services	ITS - Applications Management - Professional Fees	$50,000	To engage Enthrive for additional builds to the agent portal
September	Medi-Cal	ITS - Infrastructure - Professional Fees	ITS - Infrastructure - Other Operating Expenses - Subscriptions	$32,000	To cover the renewal subscription being higher than the anticipated amount
November	PACE	PACE Marketing - Member Communication	PACE Marketing - Advertising	$84,000	To provide additional funding needed for advertisement extension
December	Medi-Cal	Executive Office - Professional Fees	Executive Office - Professional Dues	$30,000	For the Center For Corporate Innovation membership dues
January	Medi-Cal	Medical Management - Professional Fees	Medical Management - Other Operating Expenses - Training & Seminars	$40,000	For mandatory DHCS training
January	OneCare	Quality Analytics - Purchased Services	Case Management - Purchased Services	$50,000	For the OC Members Health Education training
January	Medi-Cal	ITS - Application Development - Other Operating Expenses - HW/SW Maintenance	ITS - Applications Management - Other Operating Expenses - HW/SW Maintenance	$20,000	For additional subscription license fees
January	Medi-Cal	IS - Application Development - Human Resources Electronic Record System	IS - Application Development - Human Resources Capital Management Solution Software	$40,000	Due to project schedule extension
January	Medi-Cal	IS - Application Development - Human Capital Management Integration	IS - Application Development - Human Resources Capital Management Solution Software	$63,000	Due to project schedule extension
January	Medi-Cal	IS - Infrastructure - Compliance and Risk Management System	IS - Infrastructure - Technology Asset Inventory Tracking Application	$100,000	For addition of Service Mapping and Cloud Discovery for ServiceNow
January	Medi-Cal	Claims Administration - Purchased Services	ITS - Applications Management - Professional Fees	$27,000	For Moss Adams additional audit tool customization/enhancements
January	Medi-Cal	ITS - Applications Management - Professional Fees	ITS - Applications Management - Other Operating Expenses - HW/SW Maintenance	$48,000	For Moss Adams audit tools
February	OneCare	Communications - Printing and Postage - Member Communication	Communications - Professional Fees	$105,000	To start the initial development of the Caregiver Campaign
February	PACE	PACE Marketing - Printing and Postage - Member Communication	PACE Marketing - Other Operating Expenses - Public Activities	$10,970	For promotional items
February	Medi-Cal	Facilities - Other Operating Expenses - Computer Supply/Minor Equipment	Facilities - Other Operating Expenses - Repairs & Maintenance - Building	$100,000	For 7th and 9th floor break rooms
February	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Subscriptions	ITS - Infrastructure - Other Operating Expenses - HW/SW Maintenance	$24,140	For additional Palo Alto licenses
February	Medi-Cal	Cyber Security - Other Operating Expenses - Subscriptions	ITS - Infrastructure - Professional Fees	$240,000	For the funding of new scope of work for Axis Data Masking
February	Medi-Cal	Facilities - Printing and Postage - Postage	Facilities - Professional Fees	$60,000	To fund CBRE real estate services
February	Medi-Cal	Facilities - Office Tenant Improvements	505 Building - Front/Back Entrance Door Upgrade	$30,978	For Building 505 lobby door replacement
February	Medi-Cal	Cyber Security - Other Operating Expenses - HW/SW Maintenance	Enterprise Data and Systems Integrations - Other Operating Expenses - Maint HW/SW - GASB 96 - Variable Exp	$80,000	For Edifecs contract renewal
February	Medi-Cal	ITS - Application Development - Purchased Services	ITS - Application Development - Other Operating Expenses - HW/SW Maintenance	$150,000	For Secure Auth and DayForce InView
March	Medi-Cal	Facilities - Other Operating Expenses - Computer Supply/Minor Equipment	Facilities - Other Operating Expenses - Food Services	$15,000	For restocking breakroom supplies
March	Medi-Cal	ITS - Infrastructure - Analytics and Integration Platform for Technology Issue Response and Resolution	ITS - Infrastructure - Technology Asset Inventory Tracking Application	$25,000	For ServiceNow implementation
March	Medi-Cal	ITS - Infrastructure - Computer Operating System Patch and Repair Automation	ITS - Infrastructure - Technology Asset Inventory Tracking Application	$25,000	For ServiceNow implementation
March	Medi-Cal	ITS - Cyber Security - Professional Fees	ITS - Infrastructure - Other Operating Expenses - HW/SW Maintenance	$136,000	For Microsoft support
March	Medi-Cal	ITS - Cyber Security - Professional Fees	ITS - Infrastructure - Other Operating Expenses - HW/SW Maintenance	$12,000	For Microsoft support
March	Medi-Cal	ITS - Infrastructure - Purchased Services	ITS - Applications Management - Professional Fees	$33,000	For ServiceNow consulting
March	Medi-Cal	Quality Analytics - Professional Fees	Quality Analytics - Other Operating Expenses - Incentives	$208,190	For additional Member Health reward gift cards
April	Medi-Cal	Equity and Community Health - Incentives	Equity and Community Health - Incentives	$15,000	For members completing the SDOH surveys
April	OneCare	Customer Service - Member Communication	Cultural & Linguistic Services - Purchased Services	$24,000	For additional translations and interpreter services
April	Medi-Cal	Facilities - Audio Visual Enhancements	505 Building - Building Exterior Signage Upgrade	$107,000	For 505 building rooftop building signs project
April	Medi-Cal	500 Building - Building Exterior Signage	505 Building - Building Exterior Signage Upgrade	$142,000	For 505 building rooftop building signs project
April	Medi-Cal	ITS - Infrastructure - Professional Fees	ITS - Application Development - IS - Application Development - GASB 96 - Variable Expense	$70,000	For Sitecore amendment
April	Medi-Cal	Quality Analytics - Purchased Services	Utilization Management - Purchased Services	$84,000	For Periscope In-Home Assessments invoices
April	OneCare	Quality Analytics - Purchased Services	Utilization Management - Purchased Services	$24,000	For Periscope In-Home Assessments invoices
April	Medi-Cal	Customer Service - Member Communication	Cultural & Linguistic Services - Purchased Services	$100,000	For additional translations and interpreter services
April	Medi-Cal	Financial Analysis - Professional Fees	Cultural & Linguistic Services - Purchased Services	$149,000	For additional translations and interpreter services
April	Medi-Cal	ITS - Applications Management - Professional Fees	ITS - Applications Management - Purchased Services	$215,000	From Safety Net Connect (SNC) To SNC CalAIM - Professional System
April	Medi-Cal	ITS - Applications Management - HW/SW Maintenance	ITS - Applications Management - Purchased Services	$119,000	From SafetyNet Connect (SNC) To SNC CalAIM - Development
April	Medi-Cal	ITS - Infrastructure - Server Connectivity Maintenance and Support for Server Equipment	ITS - Infrastructure - Network Connectivity Maintenance	$54,712	For Palo Alto Firewall
April	Medi-Cal	ITS - Infrastructure - Server Connectivity Maintenance and Support for Server Equipment	ITS - Infrastructure - Maintenance of Operations and Desktop Application Software and Hardware	$24,137	From HP Server Maintenance To Operations - RightFax Maintenance & Support
April	Medi-Cal	Facilities - Professional Fees	Facilities - Professional Fees	$20,000	From CAFM To Real Estate consultant
April	Medi-Cal	ITS - Applications Management - HW/SW Maintenance	ITS - Applications Management - Professional Fees	$18,000	From SNC To [New] Synegen
April	Medi-Cal	ITS - Infrastructure - Computer Supply/Minor Equipment	ITS - Application Development - Corporate Software Maintenance	$17,500	For Grammarly Business Enterprise
April	Medi-Cal	ITS - Application Development - Purchased Services	ITS - Application Development - Purchased Services	$112,500	To repurpose funds from Ushur To American Eagle
April	Medi-Cal	ITS - Applications Management - HW/SW Maintenance	ITS - Applications Management - HW/SW Maintenance	$174,000	To repurpose funds from Find Help to Safety Net Connect
April	Medi-Cal	ITS - Infrastructure - Telecom Expense Management System, Other Ongoing Services	ITS - Applications Management - Cloud Platform Assistance, Work Station Management and Miscellaneous	$120,000	For ServiceNow Consulting SPM Phase 3
April	OneCare	Communications - Member Communication	Communications - Advertising	$150,000	For advertising sponsorship and outreach
May	Medi-Cal	Enterprise Project Mgmt Office - Training & Seminar	Strategic Development - Training & Seminar	$14,000	For Leadership Academy
May	Medi-Cal	ITS - Infrastructure - Misc HW/SW Equip Sup	IS - Cyber Security - Subscriptions	$249,000	For Zscaler
May	Medi-Cal	ITS - Infrastructure - Misc HW/SW Equip Sup	Communications - Professional Fees	$180,000	For Maricich Health
May	Medi-Cal	Medical Mgmt - Training & Seminar	Medical Mgmt - Professional Fees	$20,000	For PA consulting fees
May	OneCare	Equity and Community Health - Purchased Services	Quality Analytics - Member Communication	$45,000	For mailing and fulfillment costs for OneCare
June	Medi-Cal	IS - Application Mgmt - Maintenance HW/SW Maintenance	Legal Affairs - Professional Fees	$99,000	For general legal services
June	Medi-Cal	IS - Enterprise Data and Systems Integrations - HW/SW Maintenance	Legal Affairs - Professional Fees	$150,000	For general legal services
June	Medi-Cal	Facilities - Rent - Storage	Facilities - Rent - Equipment	$31,000	For Pitney Bowes
June	OneCare	Financial Analysis - Purch Svcs	IS - Applications Mgmt - Purch Svcs	$26,000	For general Wipro - CMS 3rd Party Processing
June	Medi-Cal	IS-Infrastructure - Prof Fees	IS - AppMgmt - Care Mgmt Sys-HealthEdge	$91,000	For HealthEdge Guiding Care
June	OneCare	Sales & Marketing - Purchased Services	Sales Marketing - Public Activities	$17,000	For OneCare promotions items
June	Medi-Cal	Quality Improvement - Professional Fees	Quality Improvement - Professional Fees	$220,000	For clinical operation reviews
June	Medi-Cal	Quality Improvement - Professional Fees	Behavioral Health Integration - Professional Fees	$170,000	For behavioral health medical reviews

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $250,000.

This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Back to Agenda

Board of Directors Meeting
August 7, 2025

Monthly Compliance Report

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

A. Updates on Regulatory Audits

1. Medicare

a. 2025 Medicare Part C and Part D Data Validation Audit (MDVA) *(applicable to OneCare)*

Update

- CalOptima Health scored 100% on both Part C and D measures.

Previously Reported

- Virtual audit sessions were held on April 1, 2025 and April 9, 2025. Source documentation has been submitted to Advent for review for Coverage Determination & Redeterminations (CDR), Medication Therapy Management (MTM), Improving Drug Utilization Review Controls (IDURC), Part C/D Grievances, Organization Determinations & Reconsiderations (ODR), and Special Needs Plan (SNP) Care Management.

b. Centers for Medicare & Medicaid Services (CMS) Three-Year Provider Network Adequacy Review *(applicable to OneCare)*

Update

- CMS' findings for the Network Adequacy review indicate "Pass" for both the Provider and Facility HSD tables.

Background:

- CMS conducts this audit every three years.
- CMS reminds Medicare Advantage (MA) organizations that they are required to maintain a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served. If CMS finds deficiencies in the contract's provider or facility network, the contract may be subject to compliance.

Back to Agenda

c. **Contract Year (CY) 2012 Contract-Specific Risk Adjustment Data Validation (RADV) Audit (CON12 RADV) *(applicable to OneCare)***

Update

- May 13, 2025 - The RADV Audit Report, Payment Error Calculation Methodology, and summary of findings were received by CalOptima Health.
- CMS calculated an overpayment amount of $54,735.41.
- Financial Analysis determined no appeal will be filed.
- CMS will send additional communications regarding overpayment collection activities related to this RADV audit once either the appeal window is closed and no appeal is submitted, or appeal processing is complete.

Background:

- CMS conducted a CY2012 RADV audit of CalOptima Health contract H5433 in 2015.
- No further communications regarding the audit were received until May 13, 2025.
- The Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) program is CMS' primary way to address overpayments to Medicare Advantage Organizations (MAOs). During a MA RADV audit, CMS confirms that any diagnoses submitted by an MAO for risk adjustment are sufficiently supported in the enrollees' medical records. If diagnoses are not sufficiently supported by the medical records, CMS may collect overpayments. MA RADV audits occur after the final risk adjustment data submission deadline for the MA contract year.

d. **CY 2019 Part C Risk Adjustment Data Validation (RADV) Audit (CON19 RADV) *(applicable to OneCare)***

Update

- June 12, 2025 - CMS notified CalOptima Health its OneCare contract (H5433) had been selected for a Payment Year (PY) 2019 Contract-Level Risk Adjustment Data Validation (CON19 RADV) audit.
- CMS will be conducting a medical record review to validate the accuracy of a subset of PY 2019 risk adjustment data and payments associated with encounters with dates of service from January 1, 2018, through December 31, 2018.
- Medical record submission window will close on September 15, 2025.
- The Financial Analysis team is leading the effort to retrieve relevant provider medical records for submission to CMS.

Background:

- The PY 2019 RADV audit will focus on risk adjusted payments made to Medicare Advantage Organizations (MAO) for the 2019 coverage year that CMS believes may be at higher risk for overpayments.

Back to Agenda

2. Medi-Cal

a. 2025 Department of Health Care Services (DHCS) Routine Medical Audit

Update

- 5/27/25: DHCS finalized its draft report and CalOptima Health received its formal CAP Request from DHCS.
- The report was consistent with the draft report with four findings.
- 6/26/25: CalOptima Health submitted its CAP response to DHCS.
- CalOptima Health will continue to track and respond to DHCS inquiries and feedback until the CAP is accepted and closed.

Audit Details and Background

- The DHCS Routine Medical Audit consisted of DHCS's review of both the Primary (aka "Main Contract") and Secondary contracts (aka "State Supported Services"). The report findings are as follows:

  - **Primary/Main Contract**
    - **4 Findings** across 3 audit categories.

Category #	Audit Area	# of Findings
1	Utilization Management	1
2	Case Management and Coordination of Care	2
3	Network and Access to Care	0
4	Member's Rights	0
5	Quality Management	0
6	Administrative and Organizational Capacity	1

  - **Secondary Contract - State Supported Services (SSS)**
    - **No Findings**

- October 23, 2024 – DHCS engaged CalOptima Health in its annual, routine medical audit.
  - The audit consisted of an evaluation of CalOptima Health's compliance with its contract and regulations in six (6) categories:
    - Utilization Management (UM)
    - Case management and coordination of care
      - New area audited in this category:
        - Enhanced Care Management (ECM)
    - Availability and accessibility
    - Member's rights
    - Quality management
    - Administrative and organizational capacity
      - New area audited in this category:
        - Encounters
  - New areas audited

Back to Agenda

- Enhanced Care Management (ECM)
- Encounters

- The audit was considered a limited-scope audit and required the participation of two (2) CalOptima Health Networks: Children's Hospital of Orange County Health Alliance (CHOC) and Optum for UM only
- Onsite interviews were conducted with CalOptima Health staff, including Medical Director, Director of Quality Management, Director of Utilization Management, Member Services Manager, Provider Relations Manager, Health Education Coordinator, Grievance Coordinator, and other staff as necessary.
- The audit involved a review of pre-onsite documents, staff interviews and medical record review.

➢ January 27, 2025 through January 29, 2025 – DHCS conducted the onsite visit with an Entrance Conference and conducted staff interviews throughout the rest of the onsite visit.

B. Regulatory Notices of Non-Compliance

➢ July 1, 2025 – DHCS issued a notice of corrective action plan for failure to provide timely access to care to a transgender member.
- Key Dates and Actions
  - July 31, 2025 - CalOptima Health is required to respond with a proposed CAP for DHCS approval.
    - > Monthly updates: CalOptima Health must provide monthly updates. The first update is due 30 calendar days from DHCS's approval of the CAP, with subsequent status updates due every 30 calendar days thereafter.
  - November 14, 2025 – All corrective actions must be completed by this date.

➢ The Regulatory Affairs & Compliance Medi-Cal department is working with impacted areas to ensure a timely response to all required deliverables.

C. Updates on Health Network Monitoring and Audits

a. Health Network Audits

➢ Heritage Provider Network - Regal Medical Group/Heritage Provider Network MSO – Lookback July 1, 2024, to March 31, 2025

D. Internal Audit Department (IAD)

a. Internal Annual Audits in Process

➢ 2024 Behavioral Health (BH) (Medi-Cal)
➢ 2025 Case Management (OneCare)

b. Internal Annual Audits Completed (May)

➢ 2025 Access & Availability (Medi-Cal) - closed on 5/5/25

c. Internal Annual Audits Completed (June)

Back to Agenda

- 2025 Case Management (Medi-Cal)- Closed on 6/2/25
- 2025 Customer Service (OneCare) - Closed on 6/17/25
- 2025 Customer Service (Medi-Cal)- Closed on 6/26/25

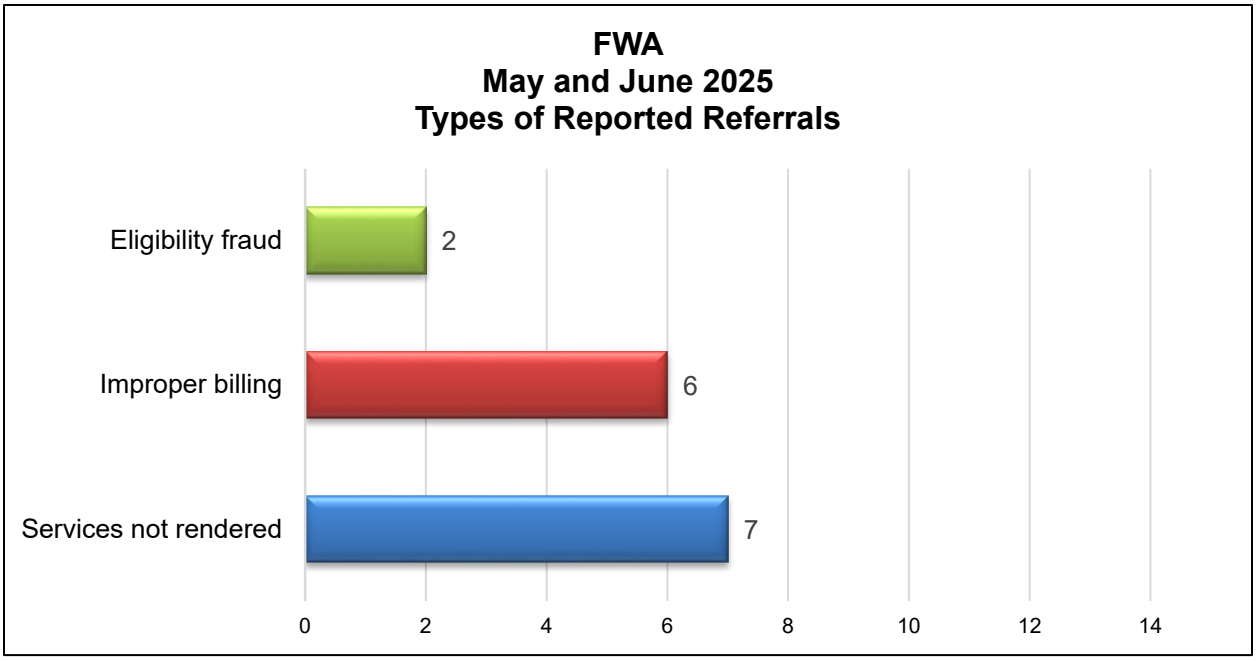
d. <u>Board-Approved Grants and Initiatives Review</u>

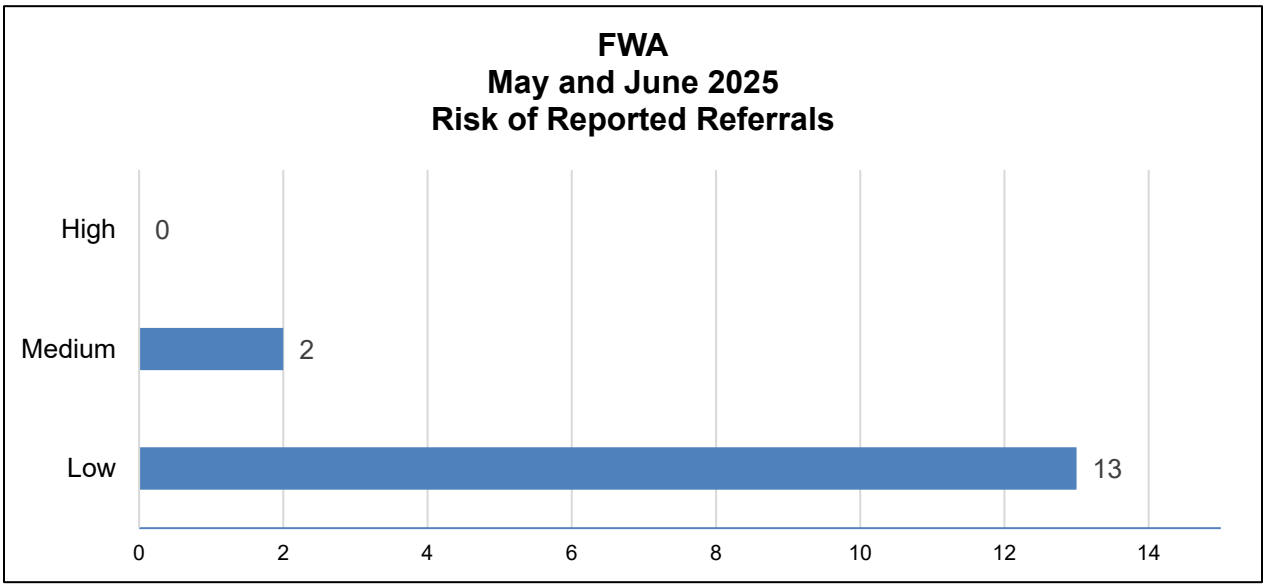
Grants currently under review include:

- Be Well/Mind OC, Irvine
  - Grant is in process. Review to resume upon close of grant after September 2025.
- Coalition of Orange County Health Clinics
  - IGT 6/7 grant for Medicated Assisted Treatment (MAT)
  - Grant is closed. Review in process.
- Housing for Health Orange County
  - Grant is closed. Review scheduling TBD.
- Talbert Medical Group dba Optum
  - Grant is closed. Review scheduling TBD.

Back to Agenda

E. Fraud, Waste & Abuse (FWA) Investigations

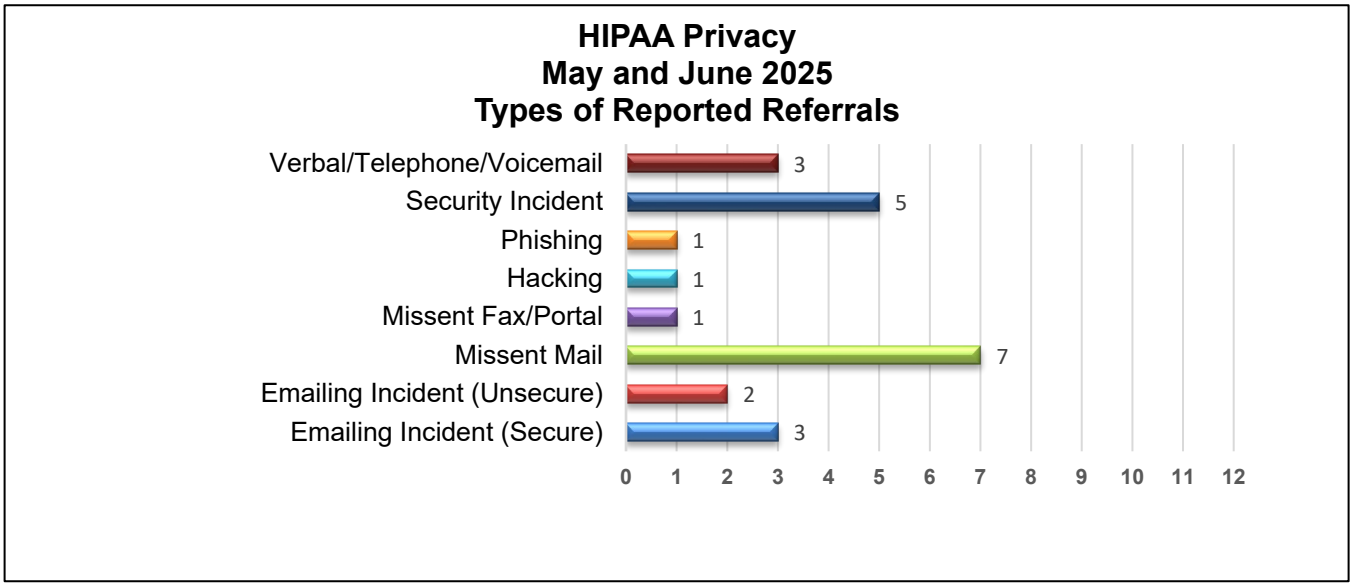


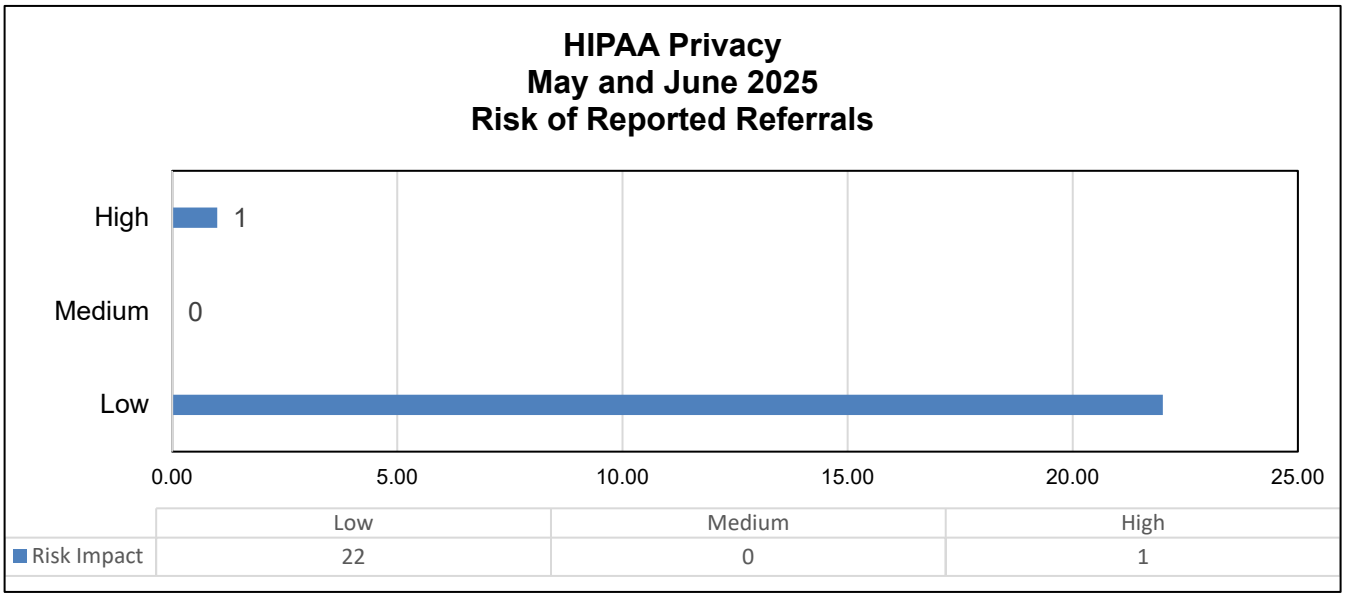


Total Number of New Cases Referred to DHCS (State)	15
Total Number of New Cases Referred to DHCS and CMS	2
Total Number of Referrals Reported	**15**

Back to Agenda

F. Privacy Update





Total Number of Referrals Reported to DHCS (State)	23
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

Back to Agenda

CHAMBER HILL

MEMORANDUM

TO: CalOptima Health
Board of Directors

FROM: Chamber Hill Strategies

DATE: July 28, 2025

SUBJECT: Board of Directors Report – August 2025

Contact with Delegation Continues, Meeting Held with Rep. Kim before July Vote

Through June and July, CalOptima Health and Chamber Hill Strategies (CHS) were in contact with offices representing CalOptima Health and Orange County in Congress about the budget reconciliation process and the potential impact of Medicaid provisions on CalOptima Health and its members. Offices contacted included: Sen. Alex Padilla (D-CA), Sen. Adam Schiff (D-CA), Rep. Lou Correa (D-CA-46), Rep. Young Kim (R-CA-40), Rep. Derek Tran (D-CA-45), Rep. Dave Min (D-CA-47), Rep. Linda Sanchez (D-CA-38), and Rep. Mike Levin (D-CA-49). On June 30, CalOptima Health Chief Executive Officer Michael Hunn met with Rep. Kim in her Anaheim office in advance of House consideration of the Senate-passed version of the budget reconciliation package (H.R. 1) where he outlined areas of concern, which included the burden and costs that proposed policy changes could have on Orange County and CalOptima Health's members.

Extended Outreach for CalOptima Health in House and Senate

CHS and CalOptima Health continued to reach beyond Orange County to highlight the importance of supporting Medicaid for CalOptima Health's members and for California. Additional outreach included the following congressional offices:

Senator Mike Crapo (R-ID), Chairman, Senate Committee on Finance, which has Senate oversight of Medicaid and Medicare policy
Senator Ron Wyden (D-OR), Ranking Member, Senate Committee on Finance
Senator Shelley Moore Capito (R-WV), member, Senate Committee on Appropriations
Senator Bill Cassidy, MD (R-LA), Chair, Senate Committee on Health, Labor, & Pensions (HELP); member, Senate Committee on Finance

- Representative David Valadao (R-CA-22), who has been a recognized leader among House Republicans on efforts to support Medicaid
- Representative Kevin Kiley (R-CA-3)

In the lead up to the final Senate and House consideration of H.R. 1, CHS engaged with House Republican offices who had previously expressed support for Medicaid, requesting relief from certain proposals impacting provider taxes and state directed payments and their support for extending implementation dates for other provisions. Offices contacted included the following:

- Representative Young Kim (R-CA-40)
- Representative David Valadao (R-CA-22)
- Representative Don Bacon (R-NE-2)
- Representative Rob Bresnahan (R-PA-8)
- Representative Juan Ciscomani (R-AZ-6)
- Representative Andrew Garbarino (R-NY-2)
- Representative Jeff Hurd (R-CO-3)
- Representative Jen Kiggans (R-VA-2)
- Representative Nick LaLota (R-NY-1)
- Representative Mike Lawler (R-NY-17)
- Representative Nicole Malliotakis (R-NY-11)
- Representative Greg Murphy (R-NC-3)
- Representative Jeff Van Drew (R-NJ-2)

House Members Send Letter on Provider Taxes and Directed Payments

CHS advocated on behalf of CalOptima Health priorities and contributed to the drafting of a letter regarding Medicaid priorities to House Republican leadership, which included language supporting protections for certain state provider taxes and state directed payments and for extending implementation dates for proposed Medicaid policy changes, including work requirements. On June 24, 16 House Republicans sent the letter to Senate Majority Leader John Thune (R-SD) and House Speaker Mike Johnson (R-LA-4) urging that a final reconciliation bill include the House's Medicaid provisions on state provider taxes and other key provisions. Rep. David Valadao (R-CA-22) led the letter, and Rep. Young Kim (R-CA-40) was among those signing the letter.

President Signs Budget Reconciliation Package (H.R. 1) into Law

On July 4, President Trump signed H.R. 1, the "One Big Beautiful Bill Act" (OBBBA), into law. The signing followed passage by the House and Senate earlier in the week. On Tuesday, July 1, the Senate, in a 51-50 vote, approved its amended version of the budget reconciliation package (H.R.1) with Vice President J.D. Vance casting the decisive, tie-breaking vote. Sens. Rand Paul (R-KY), Thom Tillis (R-NC), and Susan Collins (R-ME) joined all 47 Democratic senators in voting against H.R. 1. While much of the Senate-passed version tracked with the bill previously passed by the House on May 22, the Senate-approved bill also included changes that will impact California and other Medicaid-expansion states that have utilized provider taxes to help support their Medicaid programs. Of note, expansion states with provider taxes as of May 1, 2025, will have their provider tax rates reduced to 5.5% in 2028

with subsequent reductions of 0.5% per year until the rate reaches 3.5% in 2033. To address concerns of some senators regarding the impact of the provider tax provisions on rural states, the Senate amendment to the OBBBA allocated $50 billion to a fund with the express purpose of helping to stabilize rural hospitals. Following Senate passage, the U.S. House of Representatives cleared the legislation in a 218-214 vote on July 3 with two House Republicans, Reps. Thomas Massie (R-KY) and Brian Fitzpatrick (R-PA), joining all 212 House Democrats in voting against final passage. In the 48 hours following Senate passage, the White House and House Republican leadership were able to move multiple House Republican holdouts to secure the majority needed for final passage of the OBBBA, which was a top priority of President Trump.

Secretary Kennedy Testifies on HHS Budget, Rep. Pallone Sends Follow-Up Letter

On June 24, the House Energy and Commerce Health Subcommittee held a hearing with U.S. Health and Human Services (HHS) Secretary Robert F. Kennedy, Jr. regarding the Fiscal Year 2026 (FY26) HHS budget. Republicans praised the reorganization of HHS and the Make America Healthy Again (MAHA) Commission, while Democrats expressed concerns about Medicaid and the status of Medicare drug pricing negotiations. Secretary Kennedy framed the reorganization as a necessary modernization effort aimed at eliminating waste, fraud, and abuse. He also noted that the department's restructured framework is designed to shift HHS from a reactive posture to a more proactive, prevention-focused health model. Democratic members expressed skepticism that the reorganization would protect essential programs and services, warning that hospitals could be forced to cut services or close if Medicaid coverage is reduced or workforce pipelines are disrupted. Kennedy asserted that the budget does not cut Medicaid and insisted that coverage levels would not be reduced under the new structure. On Thursday, July 10, House Energy & Commerce Committee Ranking Member Frank Pallone (D-NJ-6) sent a letter to Secretary Kennedy as a follow-up to his June 24 testimony regarding the FY26 HHS budget. Issues highlighted in the letter included the proposed reorganization of HHS, the impact of H.R. 1 on access to health coverage, and the potential impact of the proposed budget on substance use services.

White House Releases Memo on State Directed Payments

On June 6, the Trump Administration released a memorandum titled "Eliminating Waste, Fraud, and Abuse in Medicaid," which directs the HHS Secretary to examine state directed payments (SDPs) to providers and "take appropriate action to eliminate waste, fraud, and abuse in Medicaid, including by ensuring Medicaid payments rates are not higher than Medicare, to the extent permitted by applicable law." Under the memorandum, it was not clear what action the Secretary might take, but the directive is inline with provisions regarding SDPs in the reconciliation bill (H.R. 1), which would eventually cap SDPs in Medicaid expansion states at Medicare levels.

CMS Releases Data Regarding Immigrants on Medicaid to Homeland Security

On June 13, it was reported that the Centers for Medicare and Medicaid Services (CMS) had released a dataset of immigrants enrolled in Medicaid to the Department of Homeland Security (DHS). The dataset reportedly numbers in the millions and includes enrollees in California, Illinois, Washington, and Washington, D.C. Gov. Gavin Newsom formally responded stating the action will "jeopardize the safety,

health, and security" of those whose information was shared. Following this announcement, it was reported on July 17 that CMS will be sharing the data of all 79 million Medicaid recipients with Immigration & Customs Enforcement (ICE). CalOptima Health's concerns regarding these developments have been communicated to Representatives Young Kim (R-CA-40) and David Valadao (R-CA-22).

HHS Finalizes Rule on Noncitizens in Federal Programs

On July 10, HHS released a final rule titled "Personal Responsibility and Work Opportunity Reconciliation Act of 1996; Interpretation of "Federal Public Benefit," which bans immigrants without legal status from accessing certain public programs. The rule rescinded a policy first issued in 1998 regarding implementation of the PRWORA and bans the inclusion of undocumented immigrants under a range of federal programs under the PRWORA including, but not limited to, the following: Certified Community Behavioral Health Clinics; the Community Mental Health Services Block Grant; the Community Services Block Grant; Health Workforce Programs; Mental Health and Substance Use Disorder Services; and Projects for Assistance in Transition from Homelessness Grant Program.

CMS Announces Changes to 1115 Waivers

On July 17, CMS issued 2 letters to states that will impact Medicaid 1115 waivers. First, regarding continuous eligibility, CMS stated it will not approve new 1115 waivers or extend 1115 waivers for continuous coverage, beyond the populations and durations for which continuous eligibility is available under the applicable statute. Second, regarding workforce initiatives, CMS stated it will not approve new 1115 waivers or extend existing 1115 waivers for workforce initiatives. CMS will allow currently approved initiatives to run their course but does not anticipate extending these waivers further.

CALOPTIMA HEALTH - STATE LEGISLATIVE REPORT
July 29, 2025

General Update

The Legislature recessed on July 18 for summer recess until August 18. They will then return for the final legislative push before adjourning on September 12. Before recess, attention turned to several critical deadlines: June 6 House of Origin deadline where each house had to act on its own bills; June 15 budget deadline; and July 18 policy committee deadline for the second house. The next big deadline with be August 29, which is the last day for fiscal committees in the second house to hear and report bills to the floor.

This legislative session has proven to be more unpredictable and intense than sessions in recent memory for many reasons, including: a large freshman class with ambitious agendas but little institutional memory; wildfires in Southern California; a persistent budget shortfall creating tension between the legislative houses and with the Administration; and the growing state-federal friction with the Trump Administration putting a target on California and a bulls-eye on the Governor.

Meanwhile, in mid-June, a not-so-surprising caucus revolt unseated Senate President Pro Tem Mike McGuire, who terms out in 2026, in favor of Monique Limón (D-Santa Barbara). Limón is also a short-timer who terms out in 2028 and is expected to take the helm in early 2026. While the shake-up looked seamless on the surface, bruised relationships behind the scenes have left lingering resentments. In a smoother transition, the Assembly Republicans also had a change in leadership, choosing Heath Flora (R-Ripon) as Minority Leader to succeed James Gallagher (R-Chico), who served as the Republican Caucus Leader since 2022.

Budget Update

On June 13, the Legislature approved the Budget Act of 2025 (SB 101), a skeletal spending plan to satisfy the June 15 budget deadline. The Governor signed the bill on June 27. The Budget Act details a lean framework, but the Legislature and Administration are continuing to resolve the details through trailer bills that may linger into fall.

However, this bill was not without friction. It carried steep health care cuts for undocumented Californians, even though the cuts weren't as deep as the May Revision proposal. When Senator Caroline Menjivar (D-Los Angeles) refused to support the cuts, she was immediately removed from the Health Budget Subcommittee and replaced with Budget Chair Scott Wiener (D-San Francisco). On that three-member panel, Menjivar's abstention alongside Shannon Grove (R-Bakersfield) would have flipped the vote 1-2, grinding the entire budget process to a halt.

Key Medi-Cal Savings in the Fiscal Year 2025-2026 Final Budget (vs. May Revise)
• ***UIS Enrollment Freeze:*** *Freezes enrollment of UIS adults 19+ with no age-out and a 3-month grace period*
• ***Monthly UIS Premiums:*** *$30 monthly premiums for adults ages 19-59, rather than Governor's $100 fee*
• ***GLP-1s for Weight Loss:*** *Approves Governor's elimination of prescription access for weight loss*
• ***Health Centers/Rural Health Clinics:*** *Delays Governor's proposal to cut $1.1 billion until July 2026*
• ***Dental Benefit Cuts:*** *Delays cuts from Prop 56 funds, but eliminates for UIS adults ages 19+ in July 2026*
• ***Senior Asset Test:*** *Reinstates asset limit for seniors at $130,000 rather than Governor's $2,000 proposal*
• ***MCO Tax Offset****: Approves General Fund (GF) offsets from MCO Tax (Prop 35)*
• ***Long Term Care/IHSS:*** *Rejects elimination of long-term care and IHSS benefits for UIS adults*

PACE Proposed Changes – CalOptima Health joined CalPACE in opposing an annual maintenance fee and a rate cap. The final budget included no annual maintenance fee, and the rate cap was deferred to January 2027, providing time for continued advocacy and planning should the rate cap move forward. CalOptima Health (through Clear

Advocacy) was helpful in securing signatures of nine Orange County delegation members in a joint letter to legislative leadership in support of PACE programs.

Anticipated Impacts of the Federal H.R. 1 on Medi-Cal and Covered California – The Trump Administration's H.R. 1 was signed on July 4. The California Health and Human Services Agency (CalHHS) released a webinar on July 21, outlining some of the early significant impacts statewide for the potential loss of coverage for 3.4 million people and more than $30 billion annually. View the webinar at: https://www.youtube.com/watch?v=cPgC0d_EqUo

H.R. 1 Anticipated Impacts on Medi-Cal		
Category	*By*	*Anticipated Impact*
Eligibility and Access Requirements		
Mandatory Work Requirements	01/01/27	3m lose coverage, $22b loss of federal funding, increase costs for hospitals/clinics treating uninsured
Semiannual Redeterminations	01/01/27	400k lose coverage, higher costs for hospitals/clinics treating uninsured, care disruption
Retroactive Coverage	01/01/27	86k affected annually
Cost Sharing	10/01/28	Limit access due to members delaying/foregoing care, increase in uncompensated care for providers
Financing Restrictions		
MCO Taxes	07/04/25	California's MCO tax structure is non-compliant under H.R. 1 and needs modifications generating significantly less revenue than the current tax ($2.6b). Other major provider taxes also impacted significantly.
Provider Tax Cap Ramp Down	10/01/27	Reduces 6% provider tax by .5% per year until reduced to 3.5% in 2032. Skilled nursing and intermediate care facilities are exempt. Will significantly impact all safety net providers.
Future State Directed Payments	07/04/25	Significantly limits the ability of CA to raise the nonfederal share of Medi-Cal funding going forward. May reduce provider participation since funding is diminished and decreases access to Medi-Cal.
Existing State Directed Payments (SDP) Reduction	01/01/28	Reduce payments by 10% per year until SDPs are no greater than 100% of Medicare payment levels.
Rural Health Transformation Fund	12/31/25	$10b/year for 5 years for a broad range of rural health providers
Federal Funding Repayment Penalties	10/01/29	Eliminates the ability of CMS to waive financial penalties for payment errors related to eligibility.
FMAP Reduction for UIS Emergency Medicaid	10/01/26	Increases financial pressure on safety-net hospitals with a high volume of emergency care to non-citizens. Requires increased GF spending and/or pulling back of emergency Medi-Cal services.
Immigrant Coverage Limitations		
Shifts 200K immigrant Medi-Cal members to UIS, stripping current benefits to only emergency and pregnancy-related benefits	10/01/26	Requires GF spending and/or rollback of services to cover emergency Medi-Cal benefits. May increase financial pressure on safety net providers, especially hospitals that deliver high volumes of care to non-citizens.
Abortion Provider Ban		
Bars Medi-Cal participation by providers that offer abortion	07/04/25	Decrease of $305m in federal funding causing reduced services, closure of centers, particularly in underserved areas.

H.R. 1 Anticipated Impacts on Covered California		
Category	*By*	*Anticipated Impact*
Eliminates income-based special enrollment period	2026	Lowest income enrollees cannot enroll outside annual open enrollment.
Eliminates caps on repayment of excess premium tax credits	2026	Tax credits based on projected income. If income is higher than anticipated, requires pay back of portion of credit.
Denies advanced premium tax credits	2027	Medi-Cal enrollees who lost coverage because of work requirements are denied credits.
Restricts premium tax credit eligibility to only 3 categories	2027	Lawful permanent residents, Cuban and Haitian entrants, and Compact of Free Association migrants are still eligible. 40 other categories to lose assistance.
Ends automatic passive enrollment	2028	Currently utilized by 70% of enrollees.
Ends conditional eligibility while paperwork is completed	2028	Removes a person's ability to get the tax credit during that time.

As the Administration and Legislature garner clarification from the federal government about H.R. 1, hearings are planned in August and September before the Legislature adjourns. The first informational hearing will be held on August 20 in the Assembly Budget Subcommittee on Budget and Accountability.

Since H.R. 1 includes delayed implementation dates, there is now little discussion about a Special Session in the fall or winter to adjust the budget. The Legislature and Governor are reluctant to make budget cuts before they are forced to do so by H.R. 1, laying the blame at the federal level.

Key Legislation Updates

Street Medicine – AB 543 (González-D) – Full-scope presumptive eligibility for individuals experiencing homelessness with no share of cost; would also allow a Medi-Cal member who is experiencing or at risk of homelessness to seek Medi-Cal covered services directly from any Medi-Cal provider. The bill sponsor accepted an amendment by the Local Health Plans of California (LHPC) requiring providers to contract with plans. The bill passed the Assembly floor and the Senate Health Committee unanimously and was placed on the suspense file in Senate Appropriations on July 7.

Behavioral Health Data Sharing – AB 618 (Krell-D) – Co-sponsored by LHPC and the County Behavioral Health Directors Association, this bill would require sharing of data between Medi-Cal delivery systems, including managed care plans, county mental health plans and the Medi-Cal drug program for the coordination of behavioral health services. CalOptima Health sent a letter in support of the bill. The bill passed unanimously on the Assembly Floor and in the Senate Health Committee and was placed on the Senate Appropriations suspense file on July 7.

Prior Authorization – SB 306 (Becker-D) – Would prohibit health plans from imposing prior authorization on a covered service for a period of one year, if 90% or more of requests for that service were approved in the prior year. SB 306 passed the Senate Floor and the Assembly Health Committee unanimously. The bill was amended in Assembly Appropriations on July 17 at the last minute, as a "Special Order of Business." The amendments exempted Medi-Cal managed care plans, leading LHPC to pull their opposition. CAHP remains opposed until the amendments are further understood.

Community Provider Preference for Enhanced Care Management (ECM) - SB 324 (Menjivar-D) – Senate President Pro Tem Mike McGuire-D is a Principal Co-author. This bill requires a Medi-Cal managed care plan, for purposes of

covering the ECM benefit, or if it elects to cover a Community Support, to give preference to contracting with community providers, when they are available in the county and have the applicable ECM or Community Support experience. SB 324 passed on the Senate Floor on May 27 and in the Assembly Health Committee on July 1, both with unanimous votes. The bill was amended in Assembly Appropriations on July 3, to broaden the language to allow more flexibility for managed care plans.

California's Essential Health Benefits (EHB) – SB 62 (Menjivar-D) – Proposed EHB coverage expansion includes fertility treatments (including in-vitro fertilization); annual hearing exams and hearing aids; and mobility devices (walkers, wheelchairs and scooters). SB 62 codifies the proposed changes in advance of the EHB application approval by CMS. The effective date of the new plan, if approved, is January 2027. The bill passed the Senate Floor on May 27 and the Assembly Health Committee on July 15, both unanimously. It now resides in the Assembly Appropriations Committee.

2025–26 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
SB 483 Stern	**Mental Health Diversion:** Would require that a court be satisfied that a recommended mental health treatment program is consistent with the underlying purpose of mental health diversion and meets the specialized treatment needs of the defendant. ***Potential CalOptima Health Impact*:** Increased oversight of behavioral health treatment for members.	**06/04/2025** Passed Senate floor; referred to Assembly	CalOptima Health: Watch
SB 626 Smallwood-Cuevas	**Maternal Mental Health Screenings and Treatment:** Would require a licensed health care practitioner who provides perinatal care for a patient to screen, diagnose and treat the patient for a maternal mental health condition. ***Potential CalOptima Health Impact:*** Increased access to behavioral health services for eligible members.	**06/02/2025** Passed Senate floor; referred to Assembly	CalOptima Health: Watch CAHP: Oppose
SB 812 Allen	**Qualified Youth Drop-In Center Health Care Coverage:** Would require a health plan to provide coverage for mental health and substance use disorders at a qualified youth drop-in center, defined as a center providing behavioral or primary health and wellness services to youth 12 to 25 years of age with the capacity to provide services before and after school hours and that has been designated by or embedded with a local educational agency or institution of higher education. ***Potential CalOptima Health Impact*:** Increased access to behavioral health services for CalOptima Health Medi-Cal youth members.	**05/28/2025** Passed Senate floor; referred to Assembly	CalOptima Health: Watch CAHP: Concerns
AB 37 Elhawary	**Behavioral Health Workforce:** Would require the California Workforce Development Board to study how to expand the workforce of mental health service providers providing services to homeless persons. ***Potential CalOptima Health Impact*:** Increased access to behavioral health services for members experiencing homelessness.	**03/13/2025** Referred to Assembly Labor and Employment Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 348 Krell	**Full-Service Partnership:** Would establish presumptive eligibility for Full-Service Partnership programs. ***Potential CalOptima Health Impact*:** Increased continuity of care for members with serious mental illness.	**05/12/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch
AB 384 Connolly	**Inpatient Prior Admission Authorization:** Would prohibit a health plan from requiring prior authorization for admission to medically necessary 24-hour care in inpatient settings, including general acute care hospitals and psychiatric hospitals, for mental health and substance use disorders (SUDs) as well as for any medically necessary services provided to a beneficiary while admitted for that care. ***Potential CalOptima Health Impact*:** Modified utilization management (UM) procedures for covered Medi-Cal benefits.	**04/22/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
AB 423 Davies	**Discharge and Continuing Care Planning:** Would mandate regulations for discharge and continuing care planning from a facility providing alcoholism or drug abuse recovery and treatment services, including the creation of a plan to help patients return to their home community and scheduled follow-up with a mental health or SUD professional no more than seven days after discharge. ***Potential CalOptima Health Impact*:** Increased continuity of care for members who have received SUD treatment.	**02/18/2025** Referred to Assembly Health Committee	CalOptima Health: Watch
AB 618 Krell	**Behavioral Health Data Sharing:** Would require each Medi-Cal managed care plan (MCP), county specialty mental health plan (MHP) and Drug Medi-Cal program to electronically share data for its members to support coordination of behavioral health services. Would also require the California Department of Health Care Services (DHCS) to determine minimum data elements and the frequency and format of data sharing through a stakeholder process and guidance, with final guidance to be published by January 1, 2027. ***Potential CalOptima Health Impact*:** Increased coordination between Medi-Cal delivery systems regarding behavioral health services.	**06/03/2025** Passed Assembly floor; referred to Senate	**05/07/2025** CalOptima Health: SUPPORT LHPC: Sponsor

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 877 Dixon	**Nonmedical SUD Treatment:** Would require DHCS and the California Department of Managed Health Care (DMHC) to send a letter to the chief financial officer of every health plan (including a Medi-Cal MCP) that provides SUD coverage in residential facilities. The letter must inform the plan that SUD treatment in licensed and certified residential facilities is almost exclusively nonmedical, with rare exceptions, including for billing purposes. These provisions would be repealed on January 1, 2027. ***Potential CalOptima Health Impact*:** Enhanced transparency and clarity around nonmedical treatment provided for SUDs.	**03/03/2025** Referred to Assembly Health Committee	CalOptima Health: Watch
AB 951 Ta	**Autism Diagnosis:** Would prohibit a health plan from requiring an enrollee previously diagnosed with pervasive developmental disorder or autism to receive a diagnosis to maintain coverage for behavioral health treatment for their condition. ***Potential CalOptima Health Impact*:** Increased access to care for specific behavioral health treatments.	**07/14/2025** Assembly concurred in amendments; ordered to the Governor **07/10/2025** Passed Senate floor **05/07/2025** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Budget			
H.R. 1 Arrington (TX)	**One Big Beautiful Bill Act:** Makes substantial changes to Medicaid program funding and policies, including but not limited to the following: • Work, community service and/or education requirement of 80 hours per month for able-bodied adults without dependents (with exceptions for pregnant women, foster youth, medically frail, caregivers and others), effective December 31, 2026, or no later than December 31, 2028 • Increased frequency of eligibility redeterminations for Medicaid Expansion (MCE) enrollees from annually to every six months, effective December 31, 2026 • Emergency Medicaid services provided to all undocumented beneficiaries subject to the traditional Federal Medical Assistance Percentage (FMAP) — 50% in California — regardless of the FMAP for which those would otherwise be eligible, effective October 1, 2026 Cost-sharing for MCE enrollees with incomes of 100–138% Federal Poverty Level (FPL), not to exceed $35 per service and 5% of total income, and not to be applied to primary, prenatal, pediatric, or emergency care, effective October 1, 2028 • Prohibition on any new or increased provider taxes, effective immediately • Significant restrictions on current Managed Care Organization (MCO) taxes, which could effectively repeal California's MCO tax that was recently made permanent by Proposition 35 (2024), with a potential winddown period of up to three fiscal years (FYs) ***Potential CalOptima Health Impact*:** Reduced funding to CalOptima Health and contracted providers; decreased number of members; increased administrative costs; implementation of co-pay systems; increased financial and administrative burdens for some existing members; decreased health care utilization by some existing members; reduced benefits for some existing members.	**07/04/2025** Signed into law	**05/20/2025** CalOptima Health: OPPOSE
SB 101 Wiener **AB 102** Gabriel	**Budget Act of 2025:** Makes appropriations for the government of the State of California for FY 2025-26. Total spending is $321 billion, of which $228.4 billion is from the General Fund. ***Potential CalOptima Health Impact:*** A full analysis of the FY 2025-26 Enacted State Budget is forthcoming.	**06/30/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 100 Gabriel	**Budget Acts of 2023 and 2024:** Increases Medi-Cal's current FY 2024-25 General Fund appropriation by $2.8 billion and federal funds appropriation by $8.25 billion in order to solve a deficiency in the Medi-Cal budget. ***Potential CalOptima Health Impact:*** Continued funding for current Medi-Cal rates and initiatives through June 30, 2025.	**04/14/2025** Signed into law	CalOptima Health: Watch
AB 116 Committee on Budget	**Health Omnibus Trailer Bill:** Consolidates and enacts certain budget trailer bill language containing policy changes needed to implement health-related budget expenditures. Provisions related to the Medi-Cal program include but are not limited to the following: • Enrollment freeze for undocumented individuals 19 years or older, effective no sooner than January 1, 2026, with exceptions for pregnant individuals • Implementation of $30 monthly premiums for undocumented individuals ages 19-59, effective no sooner than July 1, 2027 • Reinstatement of the asset limit at $130,000 for individuals, adding $65,000 for each additional household member, capping at 10 members, effective January 1, 2026 • Enacts PACE provider sanctions, effective immediately ***Potential CalOptima Health Impact:*** A full analysis of the FY 2025-26 Enacted State Budget is forthcoming.	**06/30/2025** Signed into law	CalOptima Health: Watch
California Advancing and Innovating Medi-Cal (CalAIM)			
SB 324 Menjivar	**Enhanced Care Management (ECM) and Community Supports Contracting:** Would require a Medi-Cal MCP to give preference to contracting with community providers when covering the ECM benefit and/or Community Supports. In addition, would require DHCS to develop standardized templates to be used by MCPs. Would also require DHCS to develop guidance to allow community providers to subcontract with other community providers. ***Potential CalOptima Health Impact*:** Increased collaboration with community providers and standardized contracts.	**05/27/2025** Passed Senate floor; referred to Assembly	CalOptima Health: Watch CAHP: Watch LHPC: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 543 Gonzalez	**Street Medicine:** Would authorize a Medi-Cal MCP to elect to offer Medi-Cal covered services through a street medicine provider. MCPs that elect to do so would be required to allow a Medi-Cal beneficiary who is experiencing homelessness to receive those services directly from a contracted street medicine provider, regardless of the beneficiary's network assignment. Additionally, would require the MCP to allow a contracted street medicine provider enrolled in Medi-Cal to directly refer the beneficiary for covered services within the appropriate network. ***Potential CalOptima Health Impact*:** Continued access to street medicine services for members experiencing homelessness.	**06/02/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch CAHP: Watch
Covered Benefits			
SB 40 Wiener	**Insulin Coverage:** Would prohibit a health plan, effective January 1, 2026 (or a policy offered in the individual or small group market, effective January 1, 2027), from imposing a copayment or other cost sharing of more than $35 for a 30-day supply of an insulin prescription drug or imposing a deductible, coinsurance, or any other cost sharing on an insulin prescription drug. Additionally, would require a health plan to cover all types of insulin without step therapy on and after January 1, 2026. ***Potential CalOptima Health Impact:*** Decreased out-of-pocket costs for future members enrolled in Covered California line of business; new UM procedures.	**05/28/2025** Passed Senate floor; referred to Assembly	CalOptima Health: Watch CAHP: Oppose
SB 62 Menjivar **AB 224** Bonta	**Essential Health Benefits (EHBs):** Would express the intent of the Legislature to review California's EHB benchmark plan and establish a new benchmark plan for the 2027 plan year. Additionally, upon approval from the United States Department of Health and Human Services and by January 1, 2027, would require the new benchmark plan include certain additional benefits, including coverage for fertility services, hearing aids and exams, and durable medical equipment. ***Potential CalOptima Health Impact:*** New covered benefits for future members enrolled in Covered California line of business.	**05/27/2025** SB 62 passed Senate floor; referred to Assembly **05/29/2025** AB 224 passed Assembly floor; referred to Senate	CalOptima Health: Watch CAHP: Concerns
SB 535 Richardson **AB 575** Arambula	**Obesity Care Access Act:** Would require an individual or group health care plan that provides coverage for outpatient prescription drug benefits to cover at least one specified anti-obesity medication and bariatric surgery for the treatment of obesity. ***Potential CalOptima Health Impact:*** Expanded covered benefits for future members enrolled in Covered California line of business.	**05/28/2025** SB 535 passed Senate floor; referred to Assembly **02/24/2025** AB 575 referred to Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 242 Boerner	**Genetic Disease Screening:** Would expand statewide newborn screenings to include Duchenne muscular dystrophy by January 1, 2027. ***Potential CalOptima Health Impact:*** Expanded covered benefits for members.	**04/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 298 Bonta	**Cost-Sharing Under Age 21:** Effective January 1, 2026, would prohibit a health plan from imposing a deductible, coinsurance, copayment, or other cost-sharing requirement for in-network health care services provided to an individual under 21 years of age, with certain exceptions for high deductible health plans that are combined with a health savings account. ***Potential CalOptima Health Impact:*** Increased costs for CalOptima Health; decreased costs for future members enrolled in Covered California line of business under 21 years of age.	**02/10/2025** Referred to Assembly Health Committee	CalOptima Health: Watch
AB 350 Bonta	**Fluoride Treatments:** Would require a health plan to provide coverage for fluoride varnish in the primary care setting for children under 21 years of age by January 1, 2026. ***Potential CalOptima Health Impact:*** New covered benefit for pediatric members.	**06/02/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch CAHP: Oppose
AB 432 Bauer-Kahan	**Menopause:** Would require a health plan to provide coverage for evaluation and treatment options for symptoms of perimenopause and menopause. Would also require a health plan to annually provide clinical care recommendations for hormone therapy to all contracted primary care providers who treat individuals with perimenopause and menopause. ***Potential CalOptima Health Impact:*** New covered benefits for members; increased communications to providers.	**06/03/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch CAHP: Oppose
AB 636 Ortega	**Diapers:** Would add diapers as a covered Medi-Cal benefit for the following individuals, contingent upon an appropriation by the Legislature: • Children greater than three years of age diagnosed with a condition that contributes to incontinence • Other individuals under 21 years of age to address a condition pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standards ***Potential CalOptima Health Impact:*** New covered benefit for pediatric members.	**04/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Eligibility and Enrollment			
AB 315 Bonta	**Home and Community-Based Alternatives (HCBA) Waiver:** Would remove the cap on the number of HCBA Waiver slots and instead require DHCS to enroll all eligible individuals who apply for HCBA Waiver services. By March 1, 2026, would require DHCS to seek any necessary waiver amendments to ensure there is sufficient capacity to enroll all individuals currently on a waiting list. Would also require DHCS by March 1, 2026, to submit a rate study to the Legislature addressing the sustainability, quality and transparency of rates for the HCBA Waiver. ***Potential CalOptima Health Impact*:** Expanded member access to HCBA Waiver services.	**03/25/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 974 Patterson	**Managed Care Enrollment Exemption:** Would exempt any dual-eligible and non-dual-eligible beneficiaries who receive services from a regional center and who use the Medi-Cal fee-for-service delivery system as a secondary form of health care coverage from mandatory enrollment in a Medi-Cal MCP. ***Potential CalOptima Health Impact:*** Decreased number of members.	**04/22/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 1012 Essayli	**Unsatisfactory Immigration Status:** Would make an individual who does not have satisfactory immigrant status ineligible for Medi-Cal benefits. In addition, would transfer funds previously appropriated for such eligibility to a newly created Serving our Seniors Fund to restore and maintain payments for Medicare Part B premiums for eligible individuals. ***Potential CalOptima Health Impact:*** Decreased number of members.	**02/21/2025** Introduced	CalOptima Health: Watch
AB 1161 Harabedian	**State of Emergency Continuous Eligibility:** Would require DHCS and the California Department of Social Services to provide continuous eligibility for its applicable programs (including Medi-Cal and CalFresh) to all beneficiaries within a geographic region who have been affected by a state of emergency or a health emergency. ***Potential CalOptima Health Impact*:** Extended Medi-Cal eligibility for certain members.	**04/29/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **04/08/2025** Passed Assembly Human Services Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Operations and Administration			
SB 278 Cabaldon	**Health Data HIV Test Results:** Would permit additional disclosures to DHCS staff and Medi-Cal MCPs to improve care coordination and quality programs for HIV-positive beneficiaries. Would also update existing laws to enhance quality improvement efforts in HIV care under Medi-Cal. Would additionally require the development of a mechanism through which Medi-Cal beneficiaries can opt out of such disclosures. ***Potential CalOptima Health Impact:*** Increased coordination of care for HIV-positive members.	**05/29/2025** Passed Senate floor; referred to Assembly	CalOptima Health: Watch
SB 497 Wiener	**Legally Protected Health Care Activity:** Would prohibit a health care provider, health plan, or contractor from releasing medical information related to a person seeking or obtaining gender-affirming health care or mental health care in response to a criminal or civil action. Would also prohibit these entities from cooperating with or providing medical information to an individual, agency, or department from another state or to a federal law enforcement agency or in response to a foreign subpoena. ***Potential CalOptima Health Impact:*** Increased protection of medical information related to gender-affirming care; increased staff training regarding disclosure processes.	**06/02/2025** Passed Senate; referred to Assembly floor	CalOptima Health: Watch
SB 530 Richardson	**Medi-Cal Time and Distance Standards:** Would extend current Medi-Cal time and distance standards until January 1, 2029. In addition, would require a Medi-Cal MCP to ensure that each subcontractor network complies with certain appointment time standards and incorporate into reporting to DHCS, unless already required to do so. Additionally, the use of telehealth providers to meet time or distance standards would not absolve the MCP of responsibility to provide a beneficiary with access, including transportation, to in-person services if the beneficiary prefers. ***Potential CalOptima Health Impact:*** Increased oversight of contracted providers; increased reporting to DHCS.	**05/29/2025** Passed Senate floor; referred to Assembly	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 660 Menjivar	**California Health and Human Services Data Exchange Framework (DxF):** Would require the Center for Data Insights and Innovation within California Health and Human Services Agency (CalHHS) to absorb all functions related to the DxF initiative, including the data sharing agreement and policies and procedures, by January 1, 2026. Additionally, would expand DxF to include social services information. ***Potential CalOptima Health Impact:*** Increased care coordination with social service providers.	**06/02/2025** Passed Senate floor; referred to Assembly	CalOptima Health: Watch
AB 40 Bonta	**Abortion as Emergency Service:** Would expand the definition of emergency services to include surgery and reproductive health services, including abortion, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. ***Potential CalOptima Health Impact:*** Expanded coverage of abortion services for members.	**04/21/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch
AB 45 Bauer-Kahan	**Reproductive Data Privacy:** Would prohibit the collection, use, disclosure, sale, sharing, or retention of the information of a person who is physically located at, or within a precise geolocation of, a family planning center, except any collection or use necessary to perform services or provide goods that have been requested. Would also authorize an aggrieved person to institute and prosecute a civil action against any person or organization in violation of these provisions. ***Potential CalOptima Health Impact:*** Increased safeguards regarding reproductive health information.	**06/03/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch
AB 257 Flora	**Specialty Telehealth Network Demonstration:** Would require the establishment of a demonstration project for a telehealth and other virtual services specialty care network designed to serve patients of safety-net providers. ***Potential CalOptima Health Impact:*** Expanded member access to telehealth specialists.	**03/25/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
AB 302 Bauer-Kahan	**Confidentiality of Medical Information Act:** Would prohibit a health care provider, health plan or contractor from complying with a court order that constitutes a foreign subpoena. Would also prohibit such entities from intentionally selling medical information or using medical information for marketing. ***Potential CalOptima Health Impact:*** Increased protection of medical information; increased staff training regarding disclosure processes.	**05/23/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 316 Krell	**Artificial Intelligence Defenses:** Prohibits a defendant that developed or used artificial intelligence from asserting a defense that artificial intelligence autonomously caused the alleged harm to the plaintiff. ***Potential CalOptima Health Impact:*** Increased liability related to UM procedures.	**05/19/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch
AB 403 Ortega	**Medi-Cal Community Health Service Workers:** Would require DHCS to annually review the Community Health Worker (CHW) benefit and present an analysis to the Legislature beginning July 1, 2027. The analyses would include an assessment of Medi-Cal MCP outreach and education efforts, CHW utilization and services, demographic disaggregation of the CHWs and beneficiaries receiving services, and fee-for-service reimbursement data. ***Potential CalOptima Health Impact:*** New reporting requirements to DHCS.	**03/25/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 577 Wilson	**Prescription Drug Antisteering:** Would prohibit a health plan or pharmacy benefit manager (PBM) from engaging in specified steering practices, including requiring an enrollee to use a retail pharmacy for dispensing prescription oral medications and imposing any requirements, conditions or exclusions that discriminate against a physician in connection with dispensing prescription oral medications. Additionally, would require a health care provider, physician's office, clinic or infusion center to obtain consent from an enrollee and disclose a good faith estimate of the applicable cost-sharing amount before supplying or administering an injected or infused medication. ***Potential CalOptima Health Impact:*** Increased oversight of contracted PBM and referral processes.	**04/29/2025** Passed Assembly Health Committee; referred to Assembly Appropriatons Committee	CalOptima Health: Watch
AB 688 Gonzalez	**Telehealth for All Act of 2025:** Beginning in 2028 and every two years thereafter, would require DHCS to use Medi-Cal data and other data sources to produce analyses in a publicly available Medi-Cal telehealth utilization report. ***Potential CalOptima Health Impact:*** New reporting requirements to DHCS.	**06/02/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch
AB 980 Arambula	**Health Plan Duty of Care:** As it pertains to the required "duty of ordinary care" by a health plan, would define "medically necessary health care service" to mean legally prescribed medical care that is reasonable and comports with the medical community standard. ***Potential CalOptima Health Impact:*** Modified UM procedures.	**04/22/2025** Re-referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Older Adult Services			
SB 242 Blakespear	**Medicare Supplemental Coverage Open Enrollment Periods:** Would make Medicare supplemental benefit plans available to qualified applicants with end stage renal disease under the age of 64 years. Would also create an annual open enrollment period for Medicare supplemental benefit plans and prohibit such plans from denying an application or adjusting premium pricing due to a preexisting condition. Additionally, would authorize premium rates offered to applicants during the open enrollment period to vary based on the applicant's age at the time of issue, but would prohibit premiums from varying based on age after the contract is issued. ***Potential CalOptima Health Impact:*** Expanded Medicare coverage options for dual-eligible members.	**04/30/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
SB 412 Limón	**Home Care Aides:** Would require a home care organization to ensure that a home care aide completes training related to the special care needs of clients with dementia prior to providing care and annually thereafter. ***Potential CalOptima Health Impact:*** New training requirements for PACE staff.	**05/08/2025** Passed Senate floor; referred to Assembly	CalOptima Health: Watch
Providers			
SB 32 Weber Pierson	**Timely Access to Care:** Would require DHCS, DMHC and the California Department of Insurance to consult stakeholders for the development and adoption of geographic accessibility standards of perinatal units to ensure timely access for enrollees by July 1, 2027. ***Potential CalOptima Health Impact:*** Additional timely access standards; increased contracting with perinatal units.	**06/02/2025** Passed Senate floor; referred to Assembly	CalOptima Health: Watch LHPC: Oppose
SB 250 Ochoa Bogh	**Medi-Cal Provider Directory — Skilled Nursing Facilities:** Would require a provider directory issued by a Medi-Cal MCP to include skilled nursing facilities as a searchable provider type. ***Potential CalOptima Health Impact:*** Modifications to CalOptima Health's online provider directory.	**05/29/2025** Passed Senate floor; referred to Assembly	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 306 Becker	**Prior Authorization Exemption:** No later than January 1, 2028, would eliminate prior authorization for medical services that are approved 90% of the time, except in cases of fraudulent provider activity or clinically inappropriate care ***Potential CalOptima Health Impact:*** Implementation of new UM procedures to assess prior authorization approval rates; decreased number of prior authorizations; decreased care coordination for members.	**05/28/2025** Passed Senate floor; referred to Assembly	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
SB 504 Laird	**HIV Reporting:** Would authorize a health care provider for a patient with an HIV infection that has already been reported to a local health officer to communicate with a local health officer or the California Department of Public Health (CDPH) to obtain public health recommendations on care and treatment or to refer the patient to services provided by CDPH. ***Potential CalOptima Health Impact:*** Increased coordination of care for HIV-positive members.	**05/08/2025** Passed Senate floor; referred to Assembly	CalOptima Health: Watch
AB 29 Arambula	**Adverse Childhood Experiences (ACEs) Screening Providers:** Would require DHCS to include community-based organizations, local health jurisdictions and doulas as qualified providers for ACEs trauma screenings and require clinical or other appropriate referrals as a condition of Medi-Cal payment for conducting such screenings. ***Potential CalOptima Health Impact:*** Increased access to care for pediatric members with ACEs.	**04/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 50 Bonta	**Over-the-Counter Contraceptives:** Would allow pharmacists to provide over-the-counter hormonal contraceptives without following certain procedures and protocols, such as requiring patients to complete a self-screening tool. As such, these requirements would become limited to prescription-only hormonal contraceptives. ***Potential CalOptima Health Impact:*** Increased member access to hormonal contraceptives.	**04/28/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch
AB 55 Bonta	**Alternative Birth Centers Licensing:** Would remove the requirement for alternative birth centers to provide comprehensive perinatal services as a condition of CDPH licensing and Medi-Cal reimbursement. ***Potential CalOptima Health Impact:*** Decreased member access to comprehensive perinatal services; reduced operating requirements for alternative birth centers.	**04/28/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch LHPC: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 220 Jackson	**Medi-Cal Subacute Care Authorization:** Would require a provider seeking prior authorization for pediatric subacute or adult subacute care services under the Medi-Cal program to submit a specified form. Additionally, would prohibit a Medi-Cal MCP from developing or using its own criteria for medical necessity and from requiring a subsequent treatment authorization request upon a patient's return from a bed hold for acute hospitalization. ***Potential CalOptima Health Impact:*** Modified UM procedures and forms.	**05/29/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch
AB 280 Aguiar-Curry	**Provider Directory Accuracy:** Would require health plans to maintain accurate provider directories, starting with minimum 60% accuracy by July 1, 2026, and increasing to 95% by July 1, 2029, or otherwise receive administrative penalties. If a patient relies on inaccurate directory information, would require the provider to be reimbursed at the out-of-network rate without the patient incurring charges beyond in-network cost-sharing amounts. Would also allow DMHC to create a standardized format to collect directory information as well as establish methodologies to ensure accuracy, such as use of a central utility, by January 1, 2026. Additionally, would require a health plan to provide information about in-network providers to enrollees upon request, including whether the provider is accepting new patients at the time, and would limit the cost-sharing amounts an enrollee is required to pay for services from those providers under specified circumstances. ***Potential CalOptima Health Impact:*** Increased oversight of CalOptima Health provider directory; increased coordination with contracted providers; increased penalty payments to DHCS.	**06/02/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose
AB 375 Nguyen	**Qualified Autism Service Paraprofessional:** Would expand the definition of "health care provider" to also include a qualified autism service paraprofessional. ***Potential CalOptima Health Impact:*** Increased access to autism services for eligible members; additional provider contracting and credentialing.	**04/08/2025** Passed Assembly Business and Professions Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 416 Krell	**Involuntary Commitment:** Would authorize a person to be taken into custody by an emergency physician under the Lanterman-Petris-Short Act and would exempt the emergency physician from criminal and civil liability. ***Potential CalOptima Health Impact:*** New legal standards for certain CalOptima Health providers.	**05/15/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 510 Addis	**Utilization Review Appeals and Grievances:** Would require that an appeal or grievance regarding a decision to delay, deny or modify health services be reviewed by a physician or peer health care professional matching the specialty of the service within two business days. In urgent cases, responses must match the urgency of the patient's condition. If these deadlines are not met, the authorization request would be automatically approved. ***Potential CalOptima Health Impact***: Expedited and modified UM, grievance and appeals procedures for covered Medi-Cal benefits; increased hiring of specialists to review grievances and appeals.	**04/22/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
AB 512 Harabedian	**Prior Authorization Timelines:** Would shorten the timeline for prior or concurrent authorization requests to no more than 24 hours via electronic submission or 48 hours via non-electronic submission for *urgent* requests and three business days via electronic submission or five business days via non-electronic submission for *standard* requests, starting from plan receipt of the information reasonably necessary and requested by the plan to make the determination. ***Potential CalOptima Health Impact***: Expedited and modified UM procedures for covered Medi-Cal benefits.	**06/03/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
AB 517 Krell	**Wheelchair Prior Authorization:** Would prohibit a Medi-Cal MCP from requiring prior authorization for the repair of a Complex Rehabilitation Technology (CRT)-powered wheelchair, if the cost of repair does not exceed $1,250. Would also no longer require a prescription or documentation of medical necessity, if the wheelchair has already been approved for use by the patient. Additionally, would require supplier documentation of the repair. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**04/08/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 539 Schiavo	**One-Year Prior Authorization Approval:** Would require a prior authorization for a health care service to remain valid for a period of at least one year, or throughout the course of prescribed treatment if less than one year, from the date of approval. ***Potential CalOptima Health Impact:*** Modified UM procedures for covered Medi-Cal benefits; decreased number of prior authorizations; increased costs.	**05/12/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 787 Papan	**Provider Directory Disclosures:** Would require a health plan to include at the top of its provider directory a statement advising an enrollee to contact the plan for assistance in finding an in-network provider. Would also require the plan to respond within one business day if contacted for such assistance and to provide a list of in-network providers confirmed to be accepting new patients within two business days. ***Potential CalOptima Health Impact:*** Expanded customer service support and staff training; technical changes to CalOptima Health's provider directory.	**05/05/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch
AB 1041 Bennett	**Provider Credentialing:** Would require a health plan to credential a provider within 90 days from the receipt of a completed application, or otherwise conditionally approve the credential. A plan would be required to notify the provider whether the application is complete within 10 days of receipt. Additionally, would require a health plan to use the standardized credentialing form on and after January 1, 2028, or six months after the form is developed, whichever is later. ***Potential CalOptima Health Impact:*** Expedited and modified credentialing procedures for interested providers.	**06/03/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose Unless Amended
Rates & Financing			
SB 339 Cabaldon	**Medi-Cal Laboratory Rates:** Would require Medi-Cal reimbursement rates for clinical laboratory or laboratory services to *equal* the lowest of the following metrics: 1. the amount billed; 2. the charge to the general public; 3. 100% of the lowest maximum allowance established by Medicare; or 4. a reimbursement rate based on an average of the lowest amount that other payers and state Medicaid programs are paying. For any such services related to the diagnosis and treatment of sexually transmitted infections on or after July 1, 2027, the Medi-Cal reimbursement rates shall not consider the rates described in clause (4) listed above. ***Potential CalOptima Health Impact*:** Increased payments to contracted clinical laboratories.	**04/29/2025** Passed Senate Judiciary Committee; referred to Senate Appropriations Committee **04/23/2025** Passed Senate Health Committee	CalOptima Health: Watch

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

CAHP: California Association of Health Plans
LHPC: Local Health Plans of California

Last Updated: July 22, 2025

2025 Federal Legislative Dates

January 3	119th Congress, 1st Session convenes
July 25–September 1	Summer recess for House
August 2–September 1	Summer recess for Senate
December 19	1st session adjourns

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

2025 State Legislative Dates

January 6	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
February 21	Last day for legislation to be introduced
April 10–20	Spring recess
May 2	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house
May 9	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house
May 23	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house
June 2–6	Floor session only
June 6	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 18	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 18–August 17	Summer recess
August 29	Last day for fiscal committees to report bills in their second house to the Floor
September 2–12	Floor session only
September 5	Last day to amend bills on the Floor
September 12	Last day for each house to pass bills; interim recess begins upon adjournment
October 12	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2025 Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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About CalOptima Health

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

CalOptima Health Community Outreach Summary — July and August 2025

Background

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

CalOptima Health's participation in public activities promotes:

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

Community Outreach Highlight

On Saturday, August 2, CalOptima Health proudly hosted its 3rd Annual Back to School Event in collaboration with the City of Westminster at the Westminster Civic Center. The event aimed to ensure children are ready to start the school year with the resources they need for health, wellness and academic success.

Families received free services and resources, including Medi-Cal and CalFresh enrollment assistance, health screenings, backpacks filled with school supplies, shoes and socks, bike helmets, hygiene kits and food and diaper distributions (while supplies lasted). Children also benefited from vision checks, eyeglasses, dental screenings, haircuts, immunizations and sports physicals.

To further enhance the experience, attendees enjoyed taco meals, cool drinks, ice cream, cultural performances and family activities, building a strong sense of community and wellness.

This event highlights CalOptima Health's ongoing commitment to improving the health and well-being of our community by offering families the support and resources needed for a successful start to the new school year.

Summary of Public Activities

As of July 16, CalOptima Health plans to participate in, organize or convene 73 public activities in July and August. There were 36 public activities in July, including 15 virtual community/collaborative meetings, 18 community events and three community-based presentations. In August, there will be 37 public activities, including 14 virtual community/collaborative meetings, 20 community events, one community-based presentation, one Community Connections Meeting and one Health Network Forum. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided two endorsements since the last reporting period (i.e., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must meet the requirements of CalOptima Health's Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for Letters of Support and Use of CalOptima Health's Name and Logo. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

1. Letter of support for UCI's proposal "Achieving Cancer Care Together for Native Hawaiians and Pacific Islanders (ACCT-NHPI)."

2. Letter of support for Chrysalis' proposal to accelerate and expand their Ladder Up program in Orange County.

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

CalOptima Health

Attachment to the August 7, 2025, CalOptima Health Outreach Summary

Community events hosted by CalOptima Health and community partners in July and August 2025:

July 2025

July 8, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Ventura/Greenacre Moraga Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 17, 4:30–7 p.m., Resource Fair, hosted by the Association of California Cities

Wild Rivers Irvine, 1000 Great Park Blvd., Irvine

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 17, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Almont/Belhaven Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 18, 3–6 p.m., Backpacks for Success Distribution Day, hosted by Community Action Partnership of Orange County

Southwest Community Center, 1601 W. 2nd St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 19, 10:30 a.m.–2 p.m., Social Recreational Resource Fair and Backpack Giveaway, hosted by Regional Center of Orange County

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

- At least one staff member attended (in person)
- Health/Resource Fair, closed to the public

July 19, 11 a.m.–2 p.m., Back-to-School Event, hosted by StandUp for Kids

StandUp for Kids, 1055 El Camino Dr. Ste. E, Costa Mesa

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

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

July 19–20, 11 a.m.–11 p.m., OC Fair, hosted by the OC Fair

OC Fair and Event Center, 88 Fair Dr., Costa Mesa

- At least five staff members attended (in person)
- Health/Resource Fair, open to the public

July 21, 8 a.m.–3 p.m., Anaheim High School's Registration Event, hosted by Anaheim High School

Anaheim High School, 811 W. Lincoln Ave., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 22, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Sumac/Sallie/Crestwood Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 22–24, 7:30 a.m.–4:30 p.m., CA MTSS Professional Learning Institute, hosted by the Orange County Department of Education

Anaheim Convention Center, 800 W. Katella Ave., Anaheim

- Sponsorship fee: $1,750; includes a resource booth and two conference registrations.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 22, 11 a.m.–Noon, CalOptima Health Medi-Cal Overview in English

Villages of California, Virtual

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

July 23, 8 a.m.–Noon, Ball Jr. High School Resource Fair, hosted by Ball Jr. High School

Ball Jr. High School, 1500 W. Ball Rd., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 24, 9 a.m.–2 p.m., Same Day Solutions Fair, hosted by the County of Orange

Saddleback Church, 1 Saddleback Pkwy., Lake Forest

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 24, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Clifton/Philadelphia Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

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

July 25, 2–3 p.m., CalOptima Health Medi-Cal Overview in English
Santa Angelina, 1308 N. Angelina Dr., Placentia
- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

July 25, 5–7 p.m., 2nd Annual Summer Extravaganza, hosted by Wings of Kindness
Mondragon Family Market, 407 E. North St., Anaheim
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 26, 8 a.m.–Noon, Community Outreach Baby Shower, hosted by Orange County Global Medical Center
Orange County Global Medical Center, 1001 North Tustin, Santa Ana
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 26, 9 a.m.–Noon, Backpacks for Success Distribution Day, hosted by Community Action Partnership of Orange County
El Modena Family Resource Center, 18672 E. Center Ave., Orange
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 29, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services
Wilhelmina/Pauline Neighborhood
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 30, 10–11:30 a.m., CalOptima Health Medi-Cal Overview in Spanish
Laura's House, Virtual
- At least one staff member presented
- Community-based organization presentation, open to members/community

July 30, 10 a.m.–Noon, Pop-Up Event, hosted by the Clinton Corner Family Campus
Clinton Corner Family Campus, 13581 Clinton St., Garden Grove
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 2025

August 2, 9 a.m.–1 p.m., Back-to-School Health and Wellness Fair, hosted by CalOptima Health and the City of Westminster
Westminster Civic Center, 8200 Westminster Blvd., Westminster
- At least 30 staff members attended (in person)
- Health/Resource Fair, open to the public

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

August 2, 9 a.m.–Noon, Newport-Mesa School Kickoff Expo, hosted by Newport-Mesa Unified School District

IKEA, 1475 S. Coast Dr., Costa Mesa

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 3, 10 a.m.–2 p.m., Back 2 School Bash, hosted by the City of Anaheim Councilmember Carlos Leon

Madison Elementary, 1510 S. Nutwood St., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 3, 10 a.m.–Noon, Back-to-School Event, hosted by Big Brothers Big Sisters of Orange County

Big Brothers Big Sisters Office, 1801 E. Edinger Ave. Ste. 101, Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 5, 11 a.m.–1 p.m., Back-to-School Backpack Distribution and Family Resource Fair, hosted by the Boys and Girls Club of Santa Ana

Boys and Girls Club of Santa Ana, 950 W. Highland St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 5, 5–8 p.m., National Night Out, hosted by the City of Garden Grove Police Department

Public Safety Building, 11301 Acacia Pkwy., Garden Grove

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 5, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Colchester/Vancouver Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 6, 3–5 p.m., Back-to-School Resource Fair, hosted by Hope through Housing

Hope through Housing Foundation, Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 7, 10 a.m.–Noon, CalOptima Health Medi-Cal Overview in English

Crime Survivors, Inc., Virtual

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

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

August 7, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Rose/Bush/Vine Neighborhood

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 7, 4–6 p.m., Back to School Fair, hosted by Fullerton School District

Nicolas Community Center, 1100 W. Olive Ave., Fullerton

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 9, 9 a.m.–12:30 p.m., Back-to-School Resource Fair, hosted by the TGR Learning Lab

TGR Learning Lab, 1 Tiger Woods Way, Anaheim

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 12, 4–6 p.m., Back-to-School Health Fair, hosted by Capistrano Unified School District and the County of Orange Social Services Agency

San Juan Elementary School, 31642 El Camino Real, San Juan Capistrano

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 15–17, 5–10 p.m., Cultural Heritage Festival, hosted by Orange County Supervisor Janet Nguyen

Freedom Hall at Mile Square Park, 16801 Euclid St., Fountain Valley

- At least ten staff members to attend (in person)
- Health/Resource Fair, open to the public

August 16, 8:30 a.m.–12:30 p.m., Project Hero Back-to-School Event, hosted by Magnolia School District

Pyles Elementary School, 10411 S. Dale Ave., Stanton

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 19, TBD, 2025 School-Based Mental Health Summit, hosted by the Orange County Department of Education

Hilton Orange County Costa Mesa, 3050 Bristol St., Costa Mesa

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 19, 11 a.m.–1 p.m., Backpacks for Success, hosted by the City of Placentia

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

- At least one staff member to attend (in person)

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

- Health/Resource Fair, open to the public

August 21, TBD, Back-to-School Night, hosted by Garfield Elementary School

Garfield Elementary School, 850 S. Brown St., Santa Ana

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 22, 5:30–8:30 p.m., Back-to-School Resource Fair, hosted by the City of Santa Ana Parks and Recreation

Garfield Community Center, 501 N. Lacy St., Santa Ana

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 23, 9 a.m.–Noon, Summer Care Fair: A Back-to-School Resource Event, hosted by Orange County Child Support Services

Orange County Child Support Services, 1055 N. Main St., Santa Ana

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 23, 5–10 p.m., Layali Little Arabia, hosted by the Arab American Civic Council

Brookhurst Plaza Inn, 711 S. Brookhurst St., Anaheim

- Sponsorship fee: $2,500; includes a resource booth, logo/banner placement on the stage backdrop, logo on promotional materials, half-page ad, email and website acknowledgement and social media feature
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 25, 9–10:30 a.m., CalOptima Health Community Connections Meeting, hosted by CalOptima Health

Virtual

- At least four staff members to attend
- Steering committee meeting, open to collaborative members

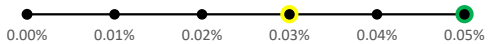
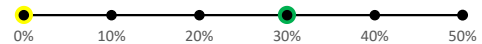
These sponsorship request(s) and community event(s) met the requirements of CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at:
https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

FY2025-2027 Strategic Plan
Organization Goals and Performance Metrics
Executive Status Report

Performance Year: FY 2025
Reporting Period: Apr 2025 - Jun 2025
Reporting Date: 7/1/2025

● = Actual ● = Target

Strategic Priority	**1.0 Equity and Population Health**
CalOptima Health will infuse the pursuit of health equity throughout our work and will continue to innovate and develop tools and interventions that advance the physical, behavioral, and social health of our members.	

Organization Goal	3-Year Performance Metrics	Owner	Key Highlights To-Date	Actual	3-Year Target	Performance Indicators
1.1 Utilize technology and innovation to strengthen equity and population health management programs.	At least 50% of the participants who complete the 12 month program will report 5% weight loss or 0.2% decrease in Hemoglobin A1c*	Marie Jeannis	• Vendor Support: Partnered with Diabetes Prevention Program (DPP) vendor, Yumlish, to define an outreach strategy, develop promotional materials, risk criteria, and rollout timeline. Vendor approval is pending credentialing and contracting process. • Remote Patient Monitoring (RPM): Developing implementation strategy for RPM in partnership with Goji and four clinic partners, including development of referral workflows, resource needs, and integration of best practices to expand access and support effective disease management.	0%	50%	 *New Measure - no data available at this time*
1.2 Implement a consistent model of care for population health/care management, including delegated networks.	Percentage of members successfully enrolled in Complex Case Management	Kelly Giardina	• Shared Complex Case Management Clinical Criteria in Health Network Forum. • Health Network clinical CM teams will share draft staffing model design in Q2 oversight meetings to plan for CCM volume increase.	0.03%	0.05%	 *.05% = ~400 members*
1.3 Annually assess members' health and social needs and utilize data to develop targeted interventions.	Percentage of members assessed for social needs and referred for appropriate interventions within 30 days*	Marie Jeannis	• Began cross-functional work to develop an enterprise-wide social needs assessment project scope, coordinated kick-off cross-functional workgroup, and initiated the process for Jiva automation to track social needs assessments completed at community events. • Began development of a measurement dashboard to determine baseline percentage.	0%	30%	 *New Measure - no data available at this time*
1.4 Increase access to preventive services for vulnerable populations in pursuit of health equity.	Percentage of compliance with Prenatal and Postpartum Care (PPC) measures**	Marie Jeannis	• ECH Community Impact Team delivered targeted maternal health education through classes, stroller walks and in-service training; reached members and staff across 21 events from April to June 2025.	50th	75th	 *Percentile based HEDIS benchmarks*

**New Measure - no data available; ** Percentile based on HEDIS benchmarks*

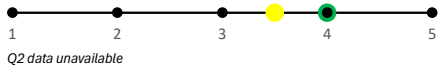
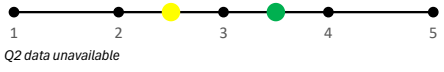
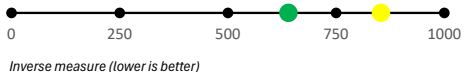
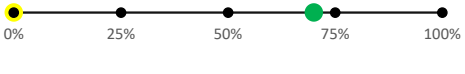
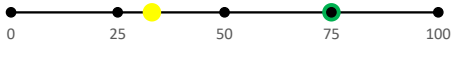
Back to Agenda

FY2025-2027 Strategic Plan
Organization Goals and Performance Metrics
Executive Status Report

Performance Year: FY 2025
Reporting Period: Apr 2025 - Jun 2025
Reporting Date: 7/1/2025

= Actual = Target

Strategic Priority	2.0 Quality and Value
CalOptima Health is committed to providing the highest quality physical, behavioral, and social health care to our members and to ensuring sound stewardship of public dollars by achieving greater value.	

Organization Goal	3-Year Performance Metrics	Owner	Key Highlights To-Date	Actual	3-Year Target	Performance Indicators
2.1 Achieve NCQA rating of 4-stars for Medi-Cal. Achieve CMS rating of 3.5-stars for Medicare.	Medi-Cal Star Rating	Linda Lee	• Completed MY2024 HEDIS data collection and reporting on June 12th. • Conducted preliminary rate analysis and identified high priority measures for focused action for remainder of CY2025.	3.5	4	 *Q2 data unavailable*
	Medicare Star Rating	Linda Lee	• Completed MY2024 HEDIS data collection and reporting on June 12th. • Conducted preliminary rate analysis and identified high priority measures for focused action for remainder of CY2025.	2.5	3.5	 *Q2 data unavailable*
2.2 Improve access to care by strengthening the delivery system through provider support and workforce initiatives.	Quarterly count of grievances related to Access and Availability	Michael Gomez	• Began collaboration with Provider Action Workgroup, to gain alignment on how the workgroup's goal overlap and can support the strategic goal. • Q2 Data still in progress, to be completed end of July.	854	640	 *Inverse measure (lower is better)*
2.3 Increase provider engagement through improved provider tools, data exchange, and collaboration.	Overall provider satisfaction score*	Michael Gomez	• Identifying potential vendors to conduct annual provider satisfaction assessment.	0%	70%	
2.4 Expand the delivery of BH services, invest in the workforce, and drive quality improvement through innovation.	Percentage of Follow-Up After Emergency Department Visit for Mental Illness (FUM) within 30 days**	Carmen Katsarov	• Completed OneCare member magnet production. • Behavioral Health Integration team co-presented with TeleMed2U at CalOptima Health Clinical Ops 2025 Health Network Series with UM & CM.	33rd	75th	 *Percentile based HEDIS benchmarks*

**New Measure - no data available; ** Percentile based on HEDIS benchmarks*

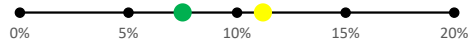
Back to Agenda

FY2025-2027 Strategic Plan
Organization Goals and Performance Metrics
Executive Status Report

Performance Year: FY 2025
Reporting Period: Apr 2025 - Jun 2025
Reporting Date: 7/1/2025

= Actual = Target

Strategic Priority	3.0 Community Partnerships and Investments
CalOptima Health will continue to demonstrate our partnership with Orange County members, providers, county agencies, and community organizations through CalAIM programs and robust community investments and partnerships to advance health, safety, and wellbeing for all members.	

Organization Goal	3-Year Performance Metrics	Owner	Key Highlights To-Date	Actual	3-Year Target	Performance Indicators
3.1 Expand social support services through Medi-Cal Transformation and other social health initiatives.	Number of members served through Street Medicine	Dr. Kelly Bruno-Nelson	• 789 Members served/435 enrolled; 30 Members permanently housed. • Expansion to Santa Ana was approved by the Board on 3/6/2025; RFP for a Street Medicine provider released with recommended provider to be presented for BOD approval in August 2025.	432	750	
3.2 Expand community involvement in co-creation of solutions that best serve members.	Number of individuals who attend or participate in community listening sessions, focus groups, or stakeholder engagement sessions*	Marie Jeannis	• Developed the Member and Provider Health Needs Assessment surveys; designed and implemented stakeholder engagement strategies, including collaboration with the Orange County Population Health Collaborative to drive inclusive and data-driven input.	0	250	*New Measure - no data available at this time*
3.3 Prioritize community investments that advance health equity, drive prevention, and improve access to care.	Percentage of net income allocated to community investments in health equity, prevention, and access to care	Donna Laverdiere	• Community Investment & Oversight Committee is continuing to review open and closed initiatives with remaining balance for next steps recommendation. • Pre-planning has begun for the Community Reinvestment program; continuing to look at voluntary investments made in 2024 and 2025. • Member and Population Health Needs Assessment project is underway to inform upcoming community investments.	11.2%	7.5%	
3.4 Ensure that all community investment programs include clear accountability metrics and regular performance monitoring requirements.	Percentage of grant agreements on track and in compliance with program objectives and budget expenditures	Dr. Kelly Bruno-Nelson	• Total active grants: 223 - Grants On Track/In Compliance: 86% (192) - Grants Delayed/Amendments in Progress: 13% (28) - Grants Watchlist: 1% (3)	86%	90%	*Based on updated performance metric amd 3-year target*

**New Measure - no data available*

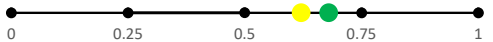
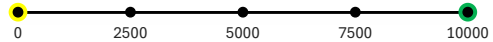
Back to Agenda

FY2025-2027 Strategic Plan
Organization Goals and Performance Metrics
Executive Status Report

Performance Year: FY 2025
Reporting Period: Apr 2025 - Jun 2025
Reporting Date: 7/1/2025

● = Actual ● = Target

Strategic Priority	**4.0 Operations, Finance and People**
Investing in our performance is vital to allowing CalOptima Health to ensure the highest level of care and service to our members across their lifespan.	

Organization Goal	3-Year Performance Metrics	Owner	Key Highlights To-Date	Actual	3-Year Target	Performance Indicators
4.1 Improve the turnaround time for treatment authorization for direct and delegated networks.	Treatment authorization processing time (business days) for all providers (Routine)	Kelly Giardina	• PA program recommendations for PA list and programmatic updates on-track for playbook completion 7/01/2025 and Board presentation for September meeting.	1.6	1.81	
	Treatment authorization processing time (business days) for all providers (Urgent)	Kelly Giardina	• PA program recommendations for PA list and programmatic updates on-track for playbook completion 7/01/2025 and Board presentation for September meeting.	0.62	0.68	
4.2 Improve the turnaround time for claims payment for direct and delegated networks.	Claims auto-adjudication rate - Medi-Cal	Ladan Khamseh	• Claims and IT continue to implement the removal of manual processing with automation logic in Facets.	84%	84%	
	Claims auto-adjudication rate - OneCare	Ladan Khamseh	• Claims and IT continue to implement the removal of manual processing with automation logic in Facets.	80%	79%	
4.3 Launch and grow programs that take care of our members and their families across their lifespan.	Membership growth by Line of Business - OneCare	Javier Sanchez	• Added new flexcard benefit and a second plan option. • New marketing vendor onboarded to develop a campaign to promote growth of OneCare.	17790	30000	
	Membership growth by Line of Business - PACE	Javier Sanchez	• Focus groups held and OneCare campaign being refreshed for annual enrollment period based on feedback collected. • New marketing campaign developed to promote growth of PACE enrollment.	515	700	
	Membership growth by Line of Business - Covered CA*	Donna Laverdiere	• Completed initial submission to DMHC to expand scope of current Knox Keene license. • Completed gap analysis conducted by operational support consultant (Deloitte).	0	10000	 *New Measure - no data available at this time*

**New Measure - no data available*

Back to Agenda

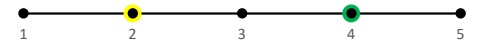
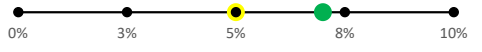
FY2025-2027 Strategic Plan
Organization Goals and Performance Metrics
Executive Status Report

Performance Year: FY 2025
Reporting Period: Apr 2025 - Jun 2025
Reporting Date: 7/1/2025

= Actual = Target

Strategic Priority	**4.0 Operations, Finance and People**

Investing in our performance is vital to allowing CalOptima Health to ensure the highest level of care and service to our members across their lifespan.

Organization Goal	3-Year Performance Metrics	Owner	Key Highlights To-Date	Actual	3-Year Target	Performance Indicators
4.4 Optimize the Medicare line of business to improve the member retention rate and support growth.	Voluntary Disenrollment rate	Javier Sanchez	• Planning to hire a Senior Manager of Outreach & Retention. • Added new flexcard benefit and a second plan which is contributing to retention and growth. • Developing provider education dinner series to improve member experience, member retention and Stars performance.	4.82%	5%	*-Inverse measure (lower is better)* *-Overall target is <5% for each calendar year end*
4.5 Implement the comprehensive Digital Transformation strategic roadmap to improve member experience and efficiency.	Percentage of Digital Transformation projects completed on time and within budget (cumulative measure)	Donna Laverdiere	• The following DT projects are on track to finish before the end of calendar year 2025 with various target dates: Finance ERP (Dec), WebMD Health Integration (Oct) , Provider Lifecycle Management (Aug), Customer Relationship Management (Sep). • IT and EPMO will complete the new portfolio plan for the approved 15 FY26 DT projects by 7/30/25.	33%	95%	*Rolling data based on project completion*
4.6 Optimize member engagement functions to improve member retention, satisfaction, and outcomes.	CAHPS Rating of Health Plan	Ladan Khamseh	After-Call Survey: January-July 1, 2025, Results: • Surveys offered: 3,213; Surveys completed: 850; Response Rate: 26%. • Satisfaction rate: 93.2% = 5 stars based on 2025 CMS Stars cut points.	2	4	
4.7 Ensure fiscal accountability and stewardship, including a balanced operating budget, quarterly budget reconciliation, and vendor and provider contracting.	Quarterly ALR measure	Nancy Huang	As of May 2025, YTD financials showed ALR at 5.0% below budgeted ALR at 6.9%. • $7.4M favorable variance in Salaries, Wages, & Benefits • $33.1M favorable variance in other administrative expense categories	5.0%	7.0%	
4.8 Launch expanded employee development and retention efforts to drive employee engagement and advancement	Percentage of open positions filled by qualified internal candidates	Steve Eckberg	• HR Strategic plan and annual objectives developed for FY26 to support infrastructure. • 41.44% of 50% goal.	41%	50%	

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 7, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

13. Select and Enter into Grant Agreement with Street Medicine Provider

Contacts

Kelly Bruno Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1) Ratify CalOptima Health issuing a Request for Proposal for the street medicine provider for the city of Santa Ana.
2) Approve the Request for Proposal Evaluation Committee recommendation for the street medicine provider for the city of Santa Ana.
3) Change the funding source for the two-year grant agreement with the selected street medicine provider by:
    a. Cancelling the March 6, 2025, Board of Directors action to appropriate up to $4.3 million from existing reserves; and
    b. Appropriating up to $4.3 million from the Intergovernmental Transfer balance resulting from a June 5, 2025, Board of Directors action,
4) Authorize the Chief Executive Officer or designee to execute a two-year grant agreement in an amount not to exceed $4.3 million in aggregate to expand CalOptima Health's Street Medicine Program with awarded Medi-Cal street medicine provider.
5) Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background

On March 17, 2022, CalOptima Health's Board (Board) committed $8 million from the Homeless Health Initiatives Reserve for purposes of Street Medicine. On May 5, 2022, the Board approved the street medicine scope of work. On November 3, 2022, the Board authorized the Chief Executive Officer to execute a contract with Healthcare in Action to provide street medicine services. The pilot launched in Garden Grove on April 1, 2023.

In accordance with CalOptima Health's Strategic Priority, Overcoming Health Disparities, and due to the success of the pilot, on October 5, 2023, the Board unanimously voted to:

1. Authorize CalOptima Health staff to expand CalOptima Health's Street Medicine Program into two additional cities.
2. Approve the Notice of Interest Opportunity process that would be released to cities, including commitments from CalOptima Health as well as evaluation criteria based on a series of questions
3. Approved the scope of work for the request for proposals (RFP) to identify providers capable of implementing the Street Medicine Program.

Back to Agenda

CalOptima Health launched the RFP for street medicine providers on November 9, 2023. On December 7, 2023, the Board authorized CalOptima Health to expand its Street Medicine Program to the cities of Anaheim and Costa Mesa. On March 7, 2024, the Board approved Celebrating Life Community Health Center to provide street medicine services in Costa Mesa and Healthcare in Action to provide street medicine services in Anaheim. The programs launched on August 12, 2024, and September 3, 2024, respectively.

In accordance with CalOptima Health's strategic priority of overcoming health disparities, and based on the success of the program, on December 5, 2024, the Board unanimously voted to approve a Notice of Interest Opportunity to identify one additional host-city for the expansion of CalOptima Health's Street Medicine Program. On March 6, 2025, the Board authorized CalOptima Health to expand its Street Medicine Program to the city of Santa Ana, approved the scope of work for the request for qualifications (RFQu) to identify providers capable of implementing the program, and appropriated up to $4.3 million to fund the two-year grant agreement with the selected street medicine provider.

At the June 5, 2025, meeting, the Board authorized closing specified Board-approved Intergovernmental Transfers (IGT) 8, 9, and 10 initiatives and transferred the remaining funds of approximately $9.0 million to unallocated reserves to deliver covered services to Medi-Cal members.

Discussion

The RFP to identify capable street medicine providers for the city of Santa Ana program was released on May 21, 2025, and invited proposals to provide Street Medicine Service services. To better align with the actual needs of the business unit, CalOptima Health opted to switch from a RFQu, which was authorized by the Board, to a Request for Proposals (RFP) as it was reviewing proposals for specific service – an action it now requests that the Board ratify. As stated in the RFP, potential providers were made aware that all applications received would be evaluated by CalOptima Health staff in accordance with the included criteria and additional sub-criteria that may be considered as relevant or pertinent by the evaluators. The scoring categories were as follows:

- Organization and completeness of proposal (10%).
- Ownership of an electronic health records system (15%).
- Demonstrated experience in providing street-based healthcare and familiarity with best practices serving unsheltered population (25%).
- Description of how the organization will meet the duties and requirements of RFP, including staffing, service delivery, and logistical capacity to operate effectively (25%).
- Organizational capacity and qualifications, including organization has staffing, training, licensing, and infrastructure (25%).

The RFP closed on June 11, 2025. CalOptima Health staff received a total of four applications. Lead by Vendor Management, the evaluators first independently reviewed, evaluated, and scored all applications

Back to Agenda

and submitted those scores to Vendor Management. The evaluators then met on June 30, 2025, to review the submitted scores to determine the next steps.

Utilizing the aforementioned evaluation criteria, the scores were as follows:

Provider	**Score**
AltaMed	90.25
Celebrating Life Community Health Center (CLCHC)	76.25
Healthcare in Action (HIA)	80.25
Serve the People - Families Together of Orange County (FTOC)	77.50

Based on the above scores, CalOptima Health staff recommend AltaMed be awarded the Street Medicine Grant Agreement in Santa Ana.

Next Steps

Similar to the existing CalOptima Health Street Medicine Program, the City of Santa Ana's program will be designed to become financially sustainable through the implementation of the California Advancing and Innovating Medi-Cal (CalAIM) services. CalOptima Health staff determined that it takes approximately two years of operations to achieve this sustainability. Therefore, staff have developed a two-year grant agreement, included as Attachment 1.

After the June 5, 2025, Board action, there is approximately $9.0 million from IGT 8, 9 and 10 that is available for reallocation. These IGT funds must be used for Medi-Cal covered services for Medi-Cal members. Staff requests changing the funding source for the two-year grant agreement with Alta Med from existing reserves to IGT funds in order to spend down newly available IGT funds. There is no change to the total appropriation requested of up to $4.3 million. CalOptima Health plans to enter into a grant agreement with the awarded Medi-Cal provider no sooner than September 2025, facilitate the program design process, and then launch street medicine services no sooner than December 2025.

Staff will provide oversight of the grant agreements pursuant to CalOptima Health Policy AA.1400p: Grants Management and will return to the Board to provide updates on the status of these grants at future meetings.

Fiscal Impact

The recommended action will appropriate up to $4.3 million from the IGT balance resulting from a previous Board action on June 5, 2025, to fund the two-year grant agreement with Alta Med.

Rationale for Recommendation

To engage CalOptima Health members experiencing homelessness, where they are and on their own terms, and to reduce or eliminate barriers to medical and social care, CalOptima Health staff recommends entering into a grant agreement with AltaMed to provide street medicine services in the city of Santa Ana.

Back to Agenda

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Draft CalOptima Health Street Medicine Grant Agreement
2. Entities Covered by this Recommended Board Action

/s/ Michael Hunn *07/31/2025*
Authorized Signature **Date**

Back to Agenda

GRANT AWARD AGREEMENT

BETWEEN

CALOPTIMA HEALTH

AND

«Provider_Grantee_Name_»

THIS GRANT AWARD AGREEMENT ("**Agreement**") is made and entered into as of «Effective_Date_» ("**Effective Date**"), by and between Orange County Health Authority, a county organized health system for the County of Orange, California dba CalOptima Health ("**CalOptima**), and «Provider_Grantee_Name_» ("**Grantee**"), a «Corporation_Type_». CalOptima and Grantee may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a public agency formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

B. CalOptima's mission is to serve its members and look after their health with excellence and dignity, respecting the value and needs of each person.

C. [insert 1-2 sentence description of the Grant Project intent].

D. Grantee desires to [insert short Grant Project description] in accordance with Grantee's grant project described in Attachment A ("**Grant Project**").

E. CalOptima finds that the Grant Project is a community program that supports and is compatible with CalOptima's mission and desires to assist Grantee in undertaking its project by providing financial support described in Attachment B ("**Grant Award**") in accordance with CalOptima's policies and procedures, subject to Grantee's compliance with the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between the Parties hereto as follows:

I. GRANTEE OBLIGATIONS

1.1 **Grantee Eligibility**. Grantee hereby warrants that it is, and shall remain throughout the term of this agreement, a «Corporation_Type_» registered in «State_in_which_Company_is_Registered».

1.2 **Grantee Activities**. Grantee agrees (i) to diligently pursue the Grant Project, as specified in Attachment A, attached hereto and incorporated herein by this reference, (ii) to use the Grant Award solely for activities as identified in Attachment A, ("**Grant Activities**"), (iii) to expend funds in accordance with this Agreement and all federal, state, and local statutes and regulations, and (iv) to return any grant funds determined to have been improperly paid, in order to avoid forfeiture of the entire Grant Award. In the event of any conflict between the Grant Project in Attachment A and the rest of this Agreement, this Agreement, including all other Attachments, shall prevail.

1.3 **Unauthorized Use of Funds**. Grantee shall use Grant Funds in accordance with this Agreement, applicable laws, and the approved Grant Activities. CalOptima retains the right to recover any and all Grant Award funds if it (or any of its regulators) determines that (i) any portion of the Grant Award was not expended as provided under the terms of this Agreement, or (ii) Grantee did not comply with the Agreement or applicable federal and state laws, regulations, guidance and/or funding source requirements.

1.4 **Limitations on Subcontracting**. The experience, knowledge, capability, and reputation of Grantee, its directors and employees were a substantial inducement for CalOptima to enter into this Agreement. Grantee shall not contract with any entity to perform the Grant Project without written approval of CalOptima. Grantee shall be fully responsible to CalOptima for the acts and omissions of its subcontractor(s), if any, as it is for the acts and omissions of persons directly employed by Grantee. In the event that CalOptima approves any subcontracting, nothing contained in this Agreement shall create any contractual relationship between any subcontractor(s) and CalOptima. All persons engaged in the work under the Grant Proposal by Grantee will be considered employees of Grantee. CalOptima will deal directly with and make payment hereunder solely to Grantee.

1.5 **Subcontracts**. To the extent that subcontracting is authorized by CalOptima under this Agreement, Grantee shall assure that all subcontracts are in writing and include any requirements of this Agreement that are appropriate to the service or activity and assure that the subcontract shall not terminate legal liability of Grantee under this Agreement.

1.6 **Communications Provisions**. Grantee must comply with CalOptima's Guidelines for Endorsements and Use of CalOptima Name or Logo policy.

1.6.1 **Use of CalOptima name or logo**: Grantee shall submit requests to CalOptima's CalAIM department, in writing, at least twenty-one (21) calendar days in advance of the date for which use of the name or logo is required. Upon receipt of a complete request for use of the CalOptima name or logo, CalOptima's CalAIM department shall review and analyze the request with input from appropriate internal departments. For more information or to submit a request, email calaim@caloptima.org. The CalAIM department shall submit a request for use of the CalOptima name or logo to the Communications Department for review and consideration and will notify Grantee in writing after a determination has been made.

1.6.2 **All other uses of CalOptima's name**: Grantees may not use CalOptima's name, including in the title of Grantee's program, without prior written approval from CalOptima.

II. GRANT PAYMENTS

2.1 **Grant Payments**. Payment of the Grant Award to Grantee under this Agreement will be as set forth in Attachment B, incorporated herein by this reference, which shall be payment in full for the Grant Project. Grantee acknowledges and agrees that this is a single Grant Award and that nothing herein obligates CalOptima to any further funding, whether for the Grant Project or future related or unrelated activities. The Parties acknowledge that the source of Grant Award funding is existing reserve funds, and not Department of Health Care Services ("**DHCS**") funds, and as such the

payments made hereunder are not subject to DHCS State Contract terms or federal or state claims processing requirements. Notwithstanding the foregoing, Grantee acknowledges and agrees that the Grant Award must be used for support and enhanced benefits to CalOptima Medi-Cal members, and is subject to the terms of this Agreement and CalOptima's policies and procedures, as applicable.

2.2 **Grant Award Use Limitations**. Grantee acknowledges and agrees that the Grant Award may not be used for achievement of milestones that have been previously paid for or will be paid for by the state or federal government or any other source. Further, Grantee acknowledges and agrees that it will not use the Grant Award to reimburse costs or liabilities it incurred prior to the date of the Grant Award.

III. WARRANTIES/COMPLIANCE WITH CALOPTIMA AND REGULATORY AGENCY RULES AND REGULATIONS

3.1 **Compliance with Applicable Laws**. In carrying out the Grant Project, Grantee shall comply with the CalOptima policies and procedures, and all other applicable CalOptima policies, as made available to Grantee on CalOptima website, as well as all federal, state and local laws, rules, and regulations.

3.2 **Health Insurance Portability and Accountability Act (HIPAA) Compliance**.

3.2.1 Grantee and CalOptima shall comply with Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), the Health Information Technology for Economic and Clinical Health ("**HITECH**") Act, the California Confidentiality of Medical Information Act ("**CMIA**"), and any regulations promulgated thereunder ("**HIPAA Requirements**") in performing their obligations under the Agreement.

3.2.2 If required by HIPAA Requirements, the Parties agree to execute CalOptima's HIPAA Business Associate Agreement, which shall be incorporated into this Agreement, and comply with the terms and conditions thereof.

3.3 **Confidentiality of Information**.

3.3.1 Grantee and its employees, agents, and subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to Grantee, its employees, agents, or subcontractors as a result of this Agreement. Grantee and its employees, agents, and subcontractors shall not use such identifying information for any purpose other than carrying out Grantee's obligations under this Agreement. Grantee and its employees, agents, and subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Grantee shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, including without limitation a finger or voice print or a photograph.

3.3.2 Notwithstanding any other provision of this Agreement, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 C.F.R. Section 431.300 *et seq.*, Welfare and Institutions Code Section 14100.2, and any regulations adopted thereunder. For the purpose of this Agreement, all information, records, data, and data elements collected and maintained for the operation of the Agreement and pertaining to Members shall be protected by Grantee from unauthorized disclosure. Grantee may release Member medical records in accordance with applicable law pertaining to the release of this type of information. Grantee 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 Agreement that is obtained by Grantee, its employees, agents or subcontractors, Grantee:

(a) Will not use any such information for any purpose other than carrying out the express terms of this Agreement,

(b) Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for medical records in accordance with applicable law,

(c) Will not disclose except as otherwise specifically permitted by this Agreement, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 C.F.R. Section 431.300 et seq., Welfare and Institutions Code Section 14100.2, and regulations adopted there under, and

(d) Will, at the termination of this Agreement, return all such information to CalOptima or maintain such information according to written procedures sent to the Grantee by CalOptima for this purpose.

3.4 **Conflicts of Interest**. No director, officer, employee, or Agent of Grantee may obtain a financial interest or benefit from the Grant Project, including any subcontracts, during their tenure with Grantee and for one (1) year thereafter. Grantee also represents and warrants that it does not have an existing financial or business relationship with any director, officer, or employee of CalOptima. Grantee and its members, officers, employees, agents, designees, and subcontractors will comply with all applicable laws and CalOptima policies regarding conflicts of interest, and Grantee shall incorporate, or cause to be incorporated, in all subcontracts relating to the Grant Project a provision that includes the requirements of this section. Grantee will immediately notify CalOptima of any violation of this Section 3.4.

IV. RECORDS AND REPORTS

4.1 **Maintain Complete Books and Records**. Grantee shall create and maintain such books and records relating to the Grant Activities performed under this Agreement as required by applicable laws and CalOptima policies and procedures. All financial records shall be maintained in accordance with generally accepted accounting principles ("**GAAP**"). Records generated in the course of carrying out this Agreement shall be maintained for ten (10) years from the date of the grant award, or the date of the completion of any audits related to this Agreement, whichever is later. Grantee shall provide CalOptima or its designated agents, within ten (10) calendar days of a written

request, information or copies of records necessary to verify and substantiate compliance with the terms of this Agreement. Grantee shall pay all duplication and postage costs associated with any audits and/or reviews necessary to ensure compliance with this Agreement or CalOptima's regulatory requirements. This Section 4.1 shall survive the termination of this Agreement.

4.2 **Reports**. Grantee shall submit all reports as specified in Attachment C, "Grant Report Schedule," attached hereto and incorporated herein by this reference.

4.3 **Monitoring**. CalOptima shall have the right to perform Grant Program and fiscal monitoring of Grantee to ensure compliance with federal and state requirements and the terms of this Agreement, including auditing, or having audited by an independent third party, Grantee regarding the Grant Project, Grant Award, and related expenses. Grantee shall fully cooperate with CalOptima's monitoring under this section, including any CalOptima auditor. Grantee must resolve any monitoring findings to CalOptima's satisfaction by the deadlines set by CalOptima and refund to CalOptima any amounts found to have been improperly expended from the Grant Award within thirty (30) days of the notice of such improper expenditures. Grantee shall be entitled to challenge any audit finding through appealing through CalOptima's grievance process.

V. INSURANCE AND INDEMNIFICATION

5.1 **Grantee Comprehensive General Liability ("CGL")/Automobile Liability**. Grantee at its sole cost and expense shall maintain such policies of comprehensive general liability and automobile liability insurance and other insurance as shall be necessary to insure it and its business addresses, customers, employees, agents, and representatives against any claim or claims for damages arising by reason of (a) personal injuries or death occasioned in connection with the carrying out the project, (b) the use of any property of the Grantee, and (c) Grant Activities performed in connection with the Agreement, with minimum coverage of one million dollars ($1,000,000) per incident/two million dollars ($2,000,000) aggregate per year.

5.2 **Workers Compensation Insurance**. Grantee at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of California and employer's liability insurance with minimum limits of liability of one million dollars ($1,000,000) per occurrence/one million dollars ($1,000,000) aggregate per year.

5.3 **Insurer Ratings**. Insurance required under this Agreement shall be provided by an insurer:

5.3.1 Rated by Best's Guide Rating with a rating of B or better; and

5.3.2 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 Section12180.7.

5.4 **Captive Risk Retention Group/Self Insured**. Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self-insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.5 **Cancellation or Material Change**. The Grantee shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Agreement without prior notification to CalOptima.

5.6 **Certificates of Insurance**. Prior to execution of this Agreement, Grantee shall provide Certificates of Insurance and additional insured endorsements to CalOptima showing the required insurance coverage and further providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and Grantee's coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

5.7 **Indemnification**. Grantee shall defend, indemnify and hold harmless CalOptima and its officers, directors, and employees from and against any and all claims (including attorneys' fees and reasonable expenses for litigation or settlement) that are related to or arise out of the Grantee's negligence, willful performance or non-performance or breach of any duties or obligations of Grantee arising under this Agreement. Neither termination of this Agreement nor completion of the acts to be performed under this Agreement shall release Grantee from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.8 **Notification of Claims**. CalOptima agrees to promptly notify Grantee of any claims or demands that arise and for which indemnification or Grantee's duty to defend hereunder is sought.

5.9 **Termination.** Sections 5.7 and 5.8 shall survive the termination of this Agreement.

VI. TERM AND TERMINATION

6.1 **Term of Agreement**. This Agreement will commence on Effective Date and will remain in effect up to and including «Term_Date» ("**Termination Date**"), or completion of the Grant Project, whichever occurs first. CalOptima Health, in its sole discretion, may extend the term of the Agreement where the Grantee has not completed the Grant Project by the Termination Date. Grantee must request such an extension in writing, setting forth good cause for the request, prior to the Termination Date. If CalOptima Health opts to grant the term extension, it shall set forth the terms and conditions of the extension in writing, including the duration of the extension and reporting requirements during the extension. If Grantee does not accept those terms and conditions, the Agreement will terminate on the Termination Date.

6.2 **Termination**. If Grantee fails to fulfill any of its duties and obligations under this Agreement, including but not limited to: (i) committing acts of unlawful discrimination; (ii) engaging

in prohibited marketing activities; and, (iii) committing fraud or abuse relating to any obligation, duty or responsibility under this Agreement (such as falsifying data in any reports; failing to maintain eligible status (non-profit in good standing), paying for services to non-Medi-Cal Member out of grant funds, etc.), CalOptima may terminate this Agreement for cause pursuant to Section 6.3.

6.3 **Termination for Cause**. Notwithstanding and in addition to any other provisions of this Agreement, CalOptima may terminate this Agreement for cause effective upon thirty (30) calendar days' prior written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 6.2. Grantee may appeal CalOptima's decision to terminate the Agreement for cause by filing a complaint pursuant to CalOptima policies and procedures. Grantee shall exhaust this administrative remedy, including requesting a hearing if permitted under CalOptima policies and procedures, for any and all Grantee complaints before commencing any civil action.

CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Agreement.

6.4 **Automatic Termination**. This Agreement shall terminate automatically if the DHCS State Contract between CalOptima and DHCS is terminated.

6.5 **Bankruptcy**. CalOptima or Grantee may terminate this Agreement with thirty (30) day written notice to the other Party in the event (i) a petition is filed in a court of record jurisdiction to declare either Party bankrupt or for reorganization under the bankruptcy laws of the United States or any similar statute of a state of the United States, or (ii) if a trustee in bankruptcy or a receiver is appointed for such Party, and such petition, trustee, or receiver, as the case may be, is not dismissed within one hundred and twenty (120) days thereof.

VII. GENERAL PROVISIONS

7.1 **Interpretation of Agreement Language**. CalOptima has the right to final interpretation of the Agreement language when disputes arise. Grantee has the right to appeal disputes concerning Agreement language to CalOptima.

7.2 **Waiver**. Any failure of a Party to insist upon strict compliance with any provision of this Agreement shall not be deemed a waiver of such provision or any other provision of this Agreement. To be effective, a waiver must be in writing that is signed and dated by the Parties.

7.3 **Assignment**. Neither this Agreement nor any of the duties delegated herein shall be assigned, delegated or transferred by Grantee without the prior written consent of CalOptima. CalOptima may assign this Agreement and its rights, interests and benefits hereunder to any entity that has at least majority control of CalOptima or to any entity whose financial solvency has been approved by Grantee, which approval shall not be unreasonably withheld. If required, any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the appropriate state and federal agencies.

7.4 **Independent Parties**. Grantee acknowledges that it is, at all times during the term of this Agreement, acting as an independent contractor under this Agreement and is not as an agent, employee, or partner of CalOptima. Grantee agrees to be solely responsible for all matters relating to compensation of its employees, including, but not limited to, compliance with laws governing workers' compensation, Social Security, withholding and payment of any and all federal, state and local personal income taxes, disability insurance, unemployment, and any other taxes for such persons, including any related employer assessment or contributions required by law, and all other regulations governing such matters, and the payment of all salary, vacation and other employee benefits. At Grantee's expense as described herein, Grantee agrees to defend, indemnify, and hold harmless CalOptima, its directors, executives, officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of Grantee's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "**Employment Claim(s)**"). Grantee shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

7.5 **Integration of Entire Agreement**. This Agreement contains all of the terms and conditions agreed upon by the Parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations, or representations of or between the Parties, either oral or written, relating to the subject matter of this Agreement that are not expressly set forth in this Agreement are null and void and of no further force or effect. All attachments to this Agreement are considered part of this Agreement and are hereby incorporated herein.

7.6 **Independent Agreement.** Nothing in this Agreement shall affect any other contractual relationships between the Parties, such as an agreement for the provision of medical services to Members. No monies paid under this Agreement may be used for the provision of services that are payable under a different contract between the Parties, or for any other purpose beyond the Grant Project as set forth in Attachment A.

7.7 **Invalidity or Unenforceability**. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other term or provision.

7.8 **Amendment**. CalOptima may amend this Agreement immediately upon written notice to Grantee in the event such amendment is required in order to maintain compliance with applicable state or federal laws. Other amendments to the Agreement shall be effective only upon mutual, written agreement of the Parties.

7.9 **No Waiver of Immunity or Privilege**. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

7.10 **Choice of Law**. This Agreement shall be governed by and construed in accordance with the laws of the State of California. The Parties consent to the jurisdiction of the California Courts with venue in Orange County, California.

7.11 **Force Majeure**. Either Party shall be excused from performance hereunder for any period that a Party is prevented from meeting the terms of this Agreement as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war, but excluding labor disputes, (a "**Force Majeure Event**") provided such Party uses commercially reasonable efforts to mitigate its effects and gives prompt written notice to the other Party. The time for the performance shall be extended for the period of delay or inability to perform due to such occurrences up to a period of ten (10) days at which time the Party unaffected by the Force Majeure Event may immediately terminate this Agreement upon written notice to the other Party without liability.

7.12 **Interpretation**. Each Party has had the opportunity to have counsel of its choice examine the provisions of this Agreement, and no implication shall be drawn against any Party by virtue of the drafting of this Agreement.

7.13 **Headings**. The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

7.14 **No Liability of County of Orange**. As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Grantee hereby acknowledge and agree that the obligations of CalOptima under this Agreement are solely the obligations of CalOptima, and that the County of Orange, State of California, shall have no obligation or liability therefor.

7.15 **Non-liability of Officials and Employees of CalOptima**. No official or employee of CalOptima shall be personally liable to Grantee in the event of any default or breach by CalOptima, or for any amount that may become due to Grantee, or any obligation under the terms of this Agreement.

7.16 **Time of Essence**. Time is of the essence in the performance of this Agreement.

7.17 **Authority to Execute**. The persons executing this Agreement on behalf of the Parties warrant that they are duly authorized to execute this Agreement, and that by executing this Agreement, the Parties are formally bound.

7.18 **Counterparts**. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall be deemed one and the same instrument.

7.19 **Notices**. All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the Party to whom notice is given, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid, addressed to the party to whom notice is to be given and such Party's address as set forth below or such other address provided by notice.

To: CalOptima Health
Attention: CEO

C/O: CalAIM
505 City Parkway West
Orange, California 92868

To: Grantee
«Provider_Grantee_Name_»
«Send_Correspondence_to_This_Person_First» «Last_Name»
«Title»
«Address»
«City», «State» «Zip»

7.20 **Dispute Resolution**.

7.20.1 Meet and Confer. If either Party has a dispute arising under or related to this Agreement, the Parties shall informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 7.20.2.

7.20.2 Arbitration. Subject to the California Government Claims Act (Cal. Gov. Code §900 *et seq*.) governing claims against public entities, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Agreement shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

7.20.3 Exclusive Remedy. With the exception of any dispute that under applicable laws may not be settled through arbitration, arbitration under Section 7.20.2 is the exclusive method

to resolve a dispute between the Parties arising out of or relating to this Agreement that is not resolved through the meet-and-confer processes.

7.20.4 Waiver. By agreeing to binding arbitration as set forth in Section 7.20.2, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

7.21 **Survival**. The following provisions of this Agreement shall survive termination or expiration of this Agreement: Sections 1.3 (Unauthorized Use of Funds), 1.6 (Communications Provisions), 3.3 (Confidentiality of Information), 4.1 (Maintain Complete Books and Records), 4.3 (Monitoring), 5.7 (Indemnification), 7.1 (Interpretation of Agreement Language), 7.2 (Waiver), 7.4 (Independent Parties), 7.7 (Invalidity or Unenforceability), 7.9 (No Waiver of Immunity or Privilege), 7.10 (Choice of Law), 7.12 (Interpretation), 7.20 (Dispute Resolution), and any other Agreement provisions that by their nature are intended to survive termination or expiration of this Agreement.

7.22 **Recitals and Exhibits**. The recitals and attachments to this Agreement are made a part of the Agreement by this reference.

VIII: SIGNATURES

IN WITNESS WHEREOF, the Parties have, by their duly authorized representatives, executed this Agreement, to be effective the date first written above:

FOR GRANTEE:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
«Signatory»_____	«CalOptima_Health_Signatory»____
PRINT NAME	PRINT NAME
«Title_of_Signatory»_____	«CalOptima_Health_Signatory_Title»
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT A
Grant Project

Grantee agrees to implement the agreed upon scope of work described in this Attachment A.

1. Overview of the Grant Program.

Grantee will operate CalOptima's Street Medicine Program in Santa Ana, California, which pairs three, integrated, key components: (1) outreach and engagement; (2) coordinated medical care that meets people where they are; and (3) Enhanced Care Management ("ECM") and Housing Navigation. Together these integrated components address acute health concerns and deploy integral preventative care but also move beyond stop-gap medical services to build the types of relationships that support a person's move to a home.

Grantee's outreach and engagement teams will consistently visit individuals in each of the encampments or hotspots in the selected service area of Santa Ana. Some medical visits, but likely not all, will be pre-identified by Grantee's outreach and engagement teams during routine canvassing. During Grantee's encounters, the medical teams will provide an array of medical services and will attempt to understand the medical and psychosocial histories of individuals to best serve them over time. Problem-solving techniques will be used to identify strengths and existing support networks to help individuals maintain their health. Every outreach and engagement touchpoint will include an attempt to connect them to housing services.

These services together will accomplish the following outcomes:

- Enroll 75% of unenrolled eligible participants into Medi-Cal
- Connect 80% of participants to an active medical home with a primary care physician
- Connect 90% of participants with ECM and Housing Navigation
- Transition 25% participants to a shelter or other housing option

CalOptima recognizes that Grantee does not have complete control over achieving these targets and will not penalize Grantee for not achieving these targets, assuming Grantee demonstrates satisfactory effort on their part to achieve them, as determined by CalOptima. This is a new project and the targets are set to track our success against a goal; CalOptima understands that in working through the development of new services, changes and unforeseen challenges can impact the collective ability to meet stated goals.

CalOptima has developed a Street Medicine Operations Manual ("Operations Manual") to detail CalOptima's Street Medicine Program. Grantee must follow the Operations Manual in order to be in compliance with this Grant Project and Agreement. CalOptima may periodically update the Operations Manual. These updates are essential to ensure that CalOptima's processes align with industry best practices, regulatory requirements, and the evolving needs of the partnership between the Parties. The updates to the Operations Manual may include, but are not limited to, changes in policies, procedures, compliance requirements, or service delivery protocols. These modifications are aimed at enhancing the efficiency, effectiveness, and compliance of the Parties' collaborative

activities. Whenever updates to the Operations Manual occur, CalOptima is committed to communicating these changes to Grantee within thirty (30) days. To streamline communication and ensure that updates are received and acknowledged in a timely manner, Grantee shall confirm its receipt and understanding of the updated Operations Manual within one week. Grantee shall implement operational changes within a timely manner, but in no event longer than thirty (30) calendar days, to ensure that the Parties' collaboration remains seamless, compliant, and aligned with the shared objectives. If the Grantee encounters any challenges or requires clarification during the implementation process, CalOptima is readily available to provide assistance and address any queries.

2. Grant Program Requirements. Grantee shall do all of the following:

2.1 Staff the Team

1. Hire and staff the team as described in the Operations Manual.
    a. Initial staffing required to launch the team, including the Project Manager, must be hired within three (3) months of the Effective Date.
2. Purchase and outfit the identified mobile medical unit from the vendor identified by CalOptima with the wrap design provided by CalOptima within three (3) months of the Effective Date.
3. Confirm all staff are trained in trauma informed care and other best practice philosophies (within one (1) month of hire).

2.2 Partnership Development

1. Develop a working partnership with key stakeholders, relevant Orange County departments, and emergency responders in Santa Ana and Orange County to identify encampments, hotspots, and key areas where people experiencing homelessness have established residence in Santa Ana.
2. Coordinate a set schedule for each outreach team and medical team to visit these key sites during the week.
3. Develop partnerships with key stakeholders and service providers in Santa Ana to make referrals and connect to the existing continuum of care.
4. Build collaborative partnership with Be Well and their mobile response units, as applicable.

2.3 Care Scheduling & Delivery

1. Identify, launch, and utilize a scheduling system for planning out service delivery.
2. Provide additional visits beyond those already scheduled by Grantee's canvassing team, as needed.
3. Design and execute a ramp up plan to deliver medical and social services in the field (billed through a separate contract and claims process) for 40 hours/week in the field.
4. Outreach to and engage unsheltered individuals through this project:
    a. 50 individuals by month 6 of the Grant Project
    b. 150 individuals by month 12 of the Grant Project
    c. 250 individuals by month 18 of the Grant Project

d. 300 individuals by month 24 of the Grant Project

5. Become the ECM and/or Community Supports ("CS") provider for unsheltered individuals (billed through a separate contract and claims process with CalOptima):
    a. 50 individuals by month 6 of the Grant Project
    b. 125 individuals by month 12 of the Grant Project
    c. 150 individuals by month 18 of the Grant Project
    d. 200 individuals by month 24 of the Grant Project

2.4 Connecting & Supportive Services

1. Use CalOptima Connect to connect individuals with ECM and CS services.
2. Connect individuals to transportation, as needed, for appointments and other services.
3. Connect individuals to local shelters.
4. Pending approval by the Orange County Continuum of Care oversight group, enter patients into the Homeless Management Information System and Coordinated Entry System for housing placement (have account access and training within 3 months).
5. Connect individuals to Social Service Agency to enroll in Medi-Cal, if not already covered.
6. Connect individuals to other supportive services.

2.5 Documentation and Invoicing

1. Submit quarterly reports to CalOptima, as specified by CalOptima and required by this Agreement, that cover the following:
    a. Number of unique persons served.
    b. Number of total visits provided.
    c. Number of referrals and linkages to ECM and CS.
    d. Number of transports coordinated.
    e. Number referred to clinic partner or other physical clinic locations.
    f. Number of individuals referred to temporary housing units, including shelter, recuperative care, and transitional housing facilities.
    g. Breakdown of services provided in the field (mobile clinic visits, street visits, telehealth, etc.)
    h. Number of individuals enrolled and/or confirmed in HMIS and CES.
    i. Number of individuals referred to SSA and enrolled in Medi-Cal.
2. Submit other reports as established in the Operations Manual and this Agreement.

3. Media & Branding.

CalOptima will serve as the branding lead for the Santa Ana Grant Project. CalOptima will provide co-branded Street Medicine and [Provider] items (*e.g.,* uniforms, flyers, etc.), designed to enhance the safety of both CalOptima's and Grantee's dedicated staff and the unhoused individuals the Parties serve. CalOptima anticipates that Grantee's staff will actively participate in wearing and using these co-branded items, fostering a cohesive and unified presence as the Parties collectively address the unique needs of the unhoused. This requirement also extends to the Street Medicine

mobile unit used under the Agreement, which will feature an exterior wrap designed by CalOptima, and include [Provider] branding on the doors of the mobile unit, to promote a consistent look within the City of Santa Ana.

Initiatives related to media engagement, spearheaded by CalOptima, will ensure effective communication and representation of the Parties' collective endeavors. CalOptima will serve as the lead contact for media relations, press announcements and public statements related to the Santa Ana Grant Project and will notify Grantee of all media opportunities in advance of them taking place. Should Grantee be contacted by a media organization about a possible media opportunity related to work performed by Grantee under the Agreement, Grantee's media team will contact CalOptima with information about the opportunity for CalOptima's consideration and consent prior to any participation.

CalOptima shall acknowledge Grantee as a partner in any press announcements, interviews or statements made by CalOptima that pertain to the Street Medicine Program and Santa Ana Grant Program, by using the phrase "in partnership with..." or a substantially similar expression approved by Grantee. Similarly, Grantee shall acknowledge CalOptima as a partner in any press announcements, interviews, or statements made by Grantee that pertain to the Street Medicine Program and Santa Ana Grant Program, by using the phrase "in partnership with" or a substantially similar expression, approved in advance by CalOptima.

ATTACHMENT B
Grant Payment

CalOptima has made a Grant Award to Grantee in the amount of «Total_Grant_Amount_Written» («Total_Grant_Amount_Numeric»), which shall be the maximum amount payable for the Grant Project and which shall be paid following execution of the Agreement in the time and manner set forth below.

Payments: Payments under this Agreement shall be made in «Number_of_Payments». «Payment_Schedule»

Return Funds: Grantee shall refund to CalOptima any funds that are found to not have been utilized in accordance with the requirements of this Agreement, including Section 2 of Attachment A. CalOptima shall have the right to audit, or to have audited by an independent third party, all Grant Project expenses. Grantee shall fully cooperate with CalOptima or its auditor and shall refund to CalOptima any amounts found to have been improperly expended from the Grant Award, including where Grantee breached the Agreement, within thirty (30) days of the notice of such improper expenditures. The potential recoupment of Grant Award funds pursuant to this section is in addition to, and not in lieu of, any other rights and remedies of CalOptima under this Agreement.

ATTACHMENT C
Report Schedule

Purpose of Grant Reports

In an effort to help ensure successful grant outcomes, CalOptima actively monitors and evaluates grant progress through monthly meetings with Grantee and requires that Grantee submit a final report. These reports are intended to help both CalOptima and Grantee appraise progress toward funding objectives.

Grant Report Requirements

All grant recipients must complete the Grant Report Form provided through written communication with CalOptima's CalAIM department. Please note that successful completion of reports are a condition of grant funding and incomplete reports will delay the disbursement of future grant payments, if multiple payments are being dispersed.

Report Submission Schedule

This grant requires the submission of «Number_of_Payments» over the duration of the project timeframe as follows:

- **Semi-Annual Progress Report** «SemiAnnual_Progress_Reports».
    - Specific due dates and Reporting Periods Covered:
        - Semi-Annual Report #1 -
        - <<MANUALLY INSERT>>

- **Final Report** will be due within thirty (30) calendar days after the end of this Grant Agreement.
    - Specific due date and Reporting Period Covered:
        - «Final_Report»

CalOptima may require additional reporting from the Grantee during the term of the Agreement, as CalOptima determines in its sole discretion.

Attachment to the August 7, 2025 Board of Directors Meeting – Agenda Item 13

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed	2040 Camfield Ave	Los Angeles	CA	90040

Back to Agenda Back to Item

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 7, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item
14. Approve Actions Related to CalOptima Health Policy AA.1400: Grant Management

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, (714) 954-2140

Recommended Actions
Approve the revised CalOptima Health Policy AA.1400: Grant Management, effective August 7, 2025.

Background
On May 4, 2023, the CalOptima Health Board of Directors (Board) adopted CalOptima Health Policy AA.1400: Grant Management to provide guidance on grant management processes related to CalOptima Health's community investments and the impact of those grants.

On October 5, 2023, the Board approved a contract amendment with Ankura Consulting Group, LLC (Ankura) to provide professional services for regulatory and contractual compliance of external grants and other internal Board-approved initiatives. Ankura conducted interviews with CalOptima Health staff regarding the grants management process and reviewed relevant documentation. After the completion of the end-to-end assessment, Ankura provided CalOptima Health leadership with a report of their observations and identified areas for improvement. The recommendations included updating the internal policy and developing a standardized process document to ensure consistent and efficient program management across business owners and program types. On December 6, 2024, the Board approved a revised policy based on those recommendations.

As CalOptima Health staff have continued to manage grant awards and projects, best practices for processes and procedures have been adopted along the way. In line with these best practices, staff are recommending revisions to AA.1400: Grant Management policy.

Discussion
CalOptima Health staff has updated Policy AA.1400: Grant Management to standardize and document improvements in grant management processes. The revised policy provides greater clarity on the distinction between a grant and a service contract, on the types of organizations eligible to receive grants, and on the process for monitoring and evaluating progress toward grant performance with implications for grant payments. The proposed changes from the current version include:

- Added language that distinguishes the difference between a grant, which is financial assistance to support a public or charitable purpose that does not include profit, and a service contract, which is a commercial agreement that procures goods or service and may include a profit to the providing entity.
- Added language that an eligible grant applicant must be a 501(c)(3) nonprofit entity, governmental body, municipality, educational institution or tribal entity in good standing with the California Secretary of State. In addition, applicants cannot have an active grant with

Back to Agenda

CalOptima Health that includes a duplicative scope of work or budget, must be in good standing with CalOptima Health, and cannot have any open investigations or legal proceedings with federal agencies.

- Added language that CalOptima Health staff will review the board of directors' composition of each grant applicant for potential conflicts of interest and advise the CalOptima Health Board accordingly.
- Added language that sets a limit for allowable indirect costs that can be funded through a grant award.
- Added language that disbursement of payments is predicated on proper expenditure of funds that have already been released.
- Added language that grantees must submit an electronic copy of their annual independent audit each year within 30 days of its completion.

CalOptima Health staff, with the assistance of outside general legal counsel, reviewed and revised the policy to ensure its provisions align with federal and state statutory and regulatory requirements. CalOptima Health staff seeks Board approval for the revised version of the policy, effective August 7, 2025.

Fiscal Impact
The recommended action has no additional fiscal impact.

Rationale for Recommendation
The revised CalOptima Health Policy AA.1400: Grant Management will provide greater assurance that CalOptima Health grant funds are being spent appropriately and that an effective grant administration process is in place to ensure regulatory and contractual compliance within CalOptima Health's operations.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Previous Board Action December 5, 2024 "Approve the revised CalOptima Health Policy AA.1400: Grant Management, effective December 5, 2024."
2. Revised CalOptima Health Policy AA.1400: Grant Management
3. Updates in Grant Oversight and Management Presentation

/s/ Michael Hunn *07/31/2025*
Authorized Signature **Date**

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
15. Approve Actions Related to CalOptima Health Policy AA.1400: Grant Management

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Donna Laverdiere, Executive Director of Strategic Development, 714-986-6981

Recommended Actions
Approve the revised CalOptima Health Policy AA.1400: Grant Management, effective December 6, 2024.

Background
On May 4, 2023, the CalOptima Health Board of Directors (Board) adopted CalOptima Health Policy AA.1400: Grant Management to provide guidance on grant management processes related to CalOptima Health's community investments and the impact of those grants.

On October 5, 2023, the Board approved a contract amendment with Ankura Consulting Group, LLC (Ankura) to provide professional services for regulatory and contractual compliance of external grants and other internal Board-approved initiatives. Ankura conducted interviews with CalOptima Health staff regarding the grants management process and reviewed relevant documentation. After the completion of the end-to-end assessment, Ankura provided CalOptima Health leadership with a report of their observations and identified areas for improvement. The recommendations included updating the internal policy and developing a standardized process document to ensure consistent and efficient program management across business owners and program types. CalOptima Health staff have implemented both recommendations.

Discussion
CalOptima Health Staff has updated Policy AA.1400: Grant Management to standardize and document improvements in grant management processes. The revised policy provides greater clarity on the procedures for each step in the grant award and management cycle and creates alignment in the overall grant program management and oversight within CalOptima Health. The proposed changes from the current version include:

- Clarification of terminology, definitions, and references;
- Additional policies and procedures in the following topic areas:
  - Ethics;
  - Grant funding approvals;
  - Grant funding opportunity documentation;
  - Grant application and evaluation processes;
  - Grant agreements and reporting requirements;
  - Grant funding disbursements;
  - Grant modifications;
  - Grant close-out and audits; and

Back to Agenda

- Other non-substantive changes (*i.e.*, formatting, spelling, punctuation, capitalization, minor clarifying language, and/or grammatical changes).

CalOptima Health staff, with the assistance of outside general legal counsel, reviewed and revised the policy to ensure its provisions align with federal and state statutory and regulatory requirements. CalOptima Health staff seeks Board approval for the revised version of the policy, effective December 5, 2024.

Fiscal Impact
The recommended action has no additional fiscal impact.

Rationale for Recommendation
The revised CalOptima Health Policy AA.1400: Grant Management will provide greater assurance that CalOptima Health grant funds are being spent appropriately and that an effective grant administration process is in place to ensure regulatory and contractual compliance within CalOptima Health's operations.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Previous Board Action May 4, 2023 "Approve New CalOptima Health Policy AA.1400p: Grant Management
2. Revised CalOptima Health Policy AA.1400: Grant Management

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken May 4, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
10. Approve New CalOptima Health Policy AA.1400p: Grant Management

Contacts
Peter Bastone, Chief Strategy Officer, (714) 246-8459
Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, (714) 954-2140

Recommended Actions
Approve new CalOptima Health Policy AA.1400p: Grant Management.

Background/Discussion
Over the past several years, CalOptima Health has made significant investment in the community through grant awards, made possible by Board-directed reserves and incentive funds. While the impact of these investments has been significant for members and the Orange County community, staff would like to codify the process around goal setting, metric development, and monitoring for grant agreements.

Through programs like the Department of Health Care Services Housing and Homelessness Incentive Program (HHIP), CalOptima Health has been, and will continue to be, the recipient of significant financial incentives that are intended to flow into the community, working to address regional health and social issues. Between the HHIP program and other revenue streams, it is anticipated that CalOptima Health will continue to award community grants over the next several years. In order to adequately steward these funds, staff have developed a policy that ensures all grant funding is tied to relevant program goals, measurable metrics that capture program impact and success, and a monitoring process to review progress toward these objectives. While staff have already been implementing these processes, CalOptima Health has not adopted a formal policy.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation
CalOptima Health staff recommends that the Board approve and adopt policy AA.1400p: Grants Management to ensure CalOptima Health can effectively distribute and monitor community investments and the impact of those grant awards.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Back to Agenda Back to Item

Attachments

1. New CalOptima Health Policy AA.1400p: Grant Management

/s/ Michael Hunn *04/26/2023*
Authorized Signature **Date**

Policy:	AA.1400p
Title:	**Grant Management**
Department:	Strategic Development
Section:	N/A
CEO Approval:	
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

For 20230504 BOD Review Only

I. PURPOSE

This policy outlines the criteria and expectations to ensure consistency and accountability in managing discretionary Grant funding disbursed by CalOptima Health.

II. POLICY

A. Approach

1. When resources permit, CalOptima Health may designate authorized funds specifically for CalOptima Health Board of Directors (hereinafter, 'Board')-approved Grants to eligible external organizations with the goal of improving the health of CalOptima Health's Members.

2. CalOptima Health shall ensure the distribution of Grant funds is reflective of CalOptima Health's mission, consistent with CalOptima Health's Strategic Plan, any Board-approved fund allocation plan, and/or any funding source legal parameters and funding restrictions. CalOptima Health shall uphold the following tenets when awarding Grants:

   a. CalOptima Health shall consider Proposals from external organizations that provide services for programs or projects aligned with CalOptima Health's mission, Strategic Plan, and/or any Board-approved fund allocation plan and directly serve CalOptima Health Members.

   b. Each Grant application shall receive a thorough, unbiased evaluation and review including an assessment of organizational experience, capacity, fiscal soundness, alignment with CalOptima Health's mission, Strategic Plan, and/or Board-approved fund allocation plan, demonstrated need, benefit to CalOptima Health Members, and feasibility.

   c. CalOptima Health shall strive for timely application approval and payment of award and shall regularly evaluate the application process to identify areas for greater efficiency.

   d. Reporting requirements for Grant awards shall align with section III.B. of this policy and shall be commensurate with the amount of funds being awarded and with the nature of the funding opportunity.

Back to Item
Back to Agenda
Back to Item

III. PROCEDURE

A. Pre-Award Assessment:

1. Grant objectives shall be in alignment with organizational strategic priorities.

2. Grant outcomes shall improve or address critical needs of CalOptima Health Members.

B. Award Grant: Establishing Goals and Metrics

1. CalOptima Health will work with Grantees to ensure that all Grants have established one or more goals that direct the use of Grant funds.

2. CalOptima Health will work with all Grantees to ensure that Grants align with one or more metrics signifying the successful accomplishment of its goal or goals. These metrics will be the basis for monitoring and reporting outcomes and successes.

C. Post-Award: Grant Monitoring and Reporting Requirements

1. CalOptima Health Operations department and/or other internal subject matter experts shall monitor a Grantee's compliance and progress towards achieving the goals presented in the Grantee's Proposal by reviewing the Grant Progress Reports.

   a. Unless otherwise specified in the Grant contract, Grantees shall submit semi-annual Grant Progress Reports, detailing Grant activities, along with any required supporting materials.

      i. The format and specific details of the Grant Progress Report shall be mutually agreed upon by CalOptima Health and the Grantee.

   b. The semi-annual Grant Progress Reports may require a breakdown of funding utilization by category as mutually agreed upon by CalOptima Health and the Grantee.

2. CalOptima Health may also utilize Grant Progress Reports to provide updates to CalOptima Health's executives and the CalOptima Health Board about its Grant funding activities.

3. Grantees shall also submit a final closeout report as stipulated in the Grant contract, summarizing the actions taken by the Grantee over the course of the entire Grant contract term.

   a. The final closeout report will include a breakdown by category of the funds used, and a reconciliation to indicate all funds were used according to the intended purpose.

4. As part of CalOptima Health's due diligence, CalOptima Health's designated representative(s) may also elect to conduct site visits to a Grantee's business premises and/or site(s) of Grant-funded service delivery during the Grant contract term for the following actions including, but not limited to:

   a. Meet the Grantee's senior leadership, as well as the Grantee's staff or volunteers with primary responsibility for conducting the funded activities;

   b. Engage in dialogue with the Grantee about progress toward project milestones and objectives, notable successes, implementation challenges, and early lessons learned;

   c. Learn of any anticipated requests for scope or budget changes, or no-cost extensions; and

For 20230504 BOD Review Only

Back to Item
Back to Agenda Back to Item

d. See program services/activities first-hand, if applicable and feasible.

5. Grant payments may be delayed or withheld if site visits and/or Grant Progress Reports reveal Grantees are not making sufficient progress towards stated goals or are not meeting other Grant contract requirements.

   a. If sufficient progress is not being made toward Grant contract goals and metrics, CalOptima Health will work with Grantees to understand why metrics were not achieved and work with the Grantee to realign metrics if deemed appropriate.

6. CalOptima Health may conduct audits of the Grantee and/or of the related CalOptima Health operational areas and financial data during the course of the Grant and/or at the conclusion of the Grant.

   a. The audits will be conducted to confirm reported expenditures, performance measures, compliance with key Grant requirements, and other relevant factors as applicable to the specific Grant.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Strategic Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective		AA.1400p	Grant Management	Administrative

For 20230504 BOD Review Only

IX. GLOSSARY

Term	Definition
Grantee	A recipient of a grant.
Grants	A financial award given by CalOptima Health to an eligible recipient to achieve a particular purpose or project. Grants are generally not expected to be repaid by the recipient when appropriately used for an approved grant project.
Member	A beneficiary enrolled in a CalOptima Health program.
Proposal	An application submitted to CalOptima Health used to formally request funding for a specific project.
Strategic Plan	CalOptima Health's strategic priorities, objectives, and action plans.

For 20230504 BOD Review Only

Policy:	AA.1400
Title:	**Grant Management**
Department:	Strategic Development
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	05/04/2023
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

For 20241205 BOD Review Only

I. PURPOSE

This policy outlines the criteria for awarding Grant funds and the expectations ~~to ensure consistency and accountability in managing~~of Grantees for discretionary Grant funding disbursed by CalOptima Health.

II. POLICY

A. Ethics

1. General Conduct

a. Each Covered Person is subject to the Conflict of Interest Laws of the State of California (State) and the CalOptima Health Code of Conduct. Any Covered Person who violates these standards will be subject to the relevant penalties, sanctions, and other disciplinary actions.

2. Gratuities, Kickbacks, and Contingency Fees

a. Except as allowed under CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments, no Covered Person may solicit or accept any personal gift or anything of value from any person or entity to which a Grant is under consideration for award, has been awarded, or may be awarded, or because of any action taken or to be taken in the performance of the Covered Person's duties. Any Covered Person failing to adhere to the above will be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, up to and including dismissal.

b. CalOptima Health employees must adhere to all provisions of CalOptima Health Policies AA.1204: Gift, Honoraria, and Travel Payments, and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health.

3. Confidential Information

a. No Covered Person may use Confidential Information, or information regarding a Grant that has not been made public or become subject to the California Public Records Act, for their actual or anticipated personal gain, or the actual or anticipated personal gain of any other person related to such Covered Person by blood, marriage, or by common commercial

Back to Agenda Back to Item

or financial interest. A Covered Person failing to adhere to this requirement will be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, up to and including dismissal.

b. No Covered Person may divulge Confidential Information to any Grantee, vendor, consultant, or contractor outside the scope of any agreement that may exist with the Grantee, vendor, consultant, or contractor.

c. While a Notice of Funding Opportunity (NOFO) is active, to prevent unfair and inequitable treatment of applicants, no Covered Person may discuss the strengths and weaknesses of an applicant with any other applicants.

4. Personal Conflict of Interest

a. No Covered Person may participate in the selection, award, or administration of an agreement with a Grantee, or in any decision that may have a foreseeable impact on a Grantee if a conflict of interest, real or apparent, exists. Such a conflict arises when a Covered Person, or a Covered Person's spouse, children, or domestic or business partner, has an existing relationship with the applicant, is employed by or has received an offer of employment from the applicant, or is in a position to influence a decision that may result in personal or financial gain to the Covered Person or the Covered Person's spouse, children, or domestic or business partner, as a result of the Grantee's selection or award.

5. Organizational Conflict of Interest

a. Organizational conflicts of interest are circumstances that arise out of a party's business or financial interests, familial relationships, contractual relationships, organizational structure, or existing or past activities, including any prior interactions or work with CalOptima Health, that result or can result in influence on requirements, such as unreleased budgets, scopes of work, selection criteria, or unequal access to information, or the appearance or reality of impropriety or unfair advantage to the party.

b. No person or entity may submit a Grant application if the person or entity has:

i. Directly assisted in drafting or in preparing the specifications, requirements, or cost estimates for that Grant; or

ii. Had access and exposure to information pertinent to that Grant that was unavailable to other potential applicants and would provide a competitive advantage to its possessor.

~~A.~~B. Approach to Grant Management

1. When resources permit, CalOptima Health may designate authorized funds specifically for ~~CalOptima Health Board of Directors (hereinafter, 'Board')~~ Board-approved ~~Grants~~Grant(s) to eligible external organizations ~~with the goal of improving the health of CalOptima Health's Members.~~ .

2. CalOptima Health ~~shall~~will ensure the distribution of Grant funds is reflective of CalOptima Health's mission, consistent with CalOptima Health's Strategic Plan, any Board-approved fund allocation plan, and/or any funding source legal parameters and funding restrictions. ~~CalOptima Health shall uphold the following tenets when awarding Grants:~~

For 2024 12-5 BOD Review Only

a. CalOptima Health shall consider Proposals from external organizations that provide services for programs or projects aligned with CalOptima Health's mission, Strategic Plan, and/or any Board-approved fund allocation plan and directly serve CalOptima Health Members.

3. Each Grant application shallApplication will receive a thorough, unbiased evaluation and review including, but not limited to, an assessment of organizationalan organization's experience, capacity, fiscal soundness, alignment with CalOptima Health's mission, Strategic Plan, and/or Board-approved fund allocation plan, demonstrated need, benefit to CalOptima Health Members, and feasibility.

b. CalOptima Health shall strive for timely application approval and payment of award and shall regularly evaluate the application process to identify areas for greater efficiency.

c. Reporting requirements for Grant awards shall align with section III.B. of this policy and shall be commensurate with the amount of funds being awarded and with the nature of the funding opportunity.

C. Approvals

1. Funding and funding reallocation for all Grant Awards will be approved by the Board through separate Board actions.

D. Grant Award Funds

1. Grant Award fund disbursements may only be approved by an authorized person pursuant to CalOptima Health's Policy GA.5002: Purchasing.

2. Any person in a position of delegated authority may designate a person of the same level or higher, in writing, to act in their stead when that person is unavailable.

3. Grant fund disbursement approval limits will be consistent with CalOptima Health's Policy GA.5002: Purchasing:

Employee Position	Approval Limit
Manager	$ 1,000
Director	$ 10,000
Executive Director or Officer	$ 100,000
CEO or Chief Operating Officer (COO)	$ Over 100,000

III. PROCEDURE

A. Pre-Award Assessment:

A. : Grant Authorization Requirements

1. Grants Management will coordinate program development and provide guidance on the grant-making process to initiative owners and/or Sponsoring Department as appropriate.

2. The Sponsoring Department will develop the requirements and criteria for the specific Grant.

3. The Sponsoring Department will develop a NOFO that outlines specific information about the Grant program. Refer to Section III.B. for NOFO requirements.

For 2024 1205 BOD Review Only

4. The Sponsoring Department will complete a CalOptima Health Board Action Agenda Referral (COBAR) for Board authorization of the Grant program.

B. Notice of Funding Opportunity (NOFO) Requirements

1. CalOptima Health will issue a NOFO for all Grant programs.

2. At a minimum, each NOFO will contain the following elements:

a. The title of the Grant program;

b. Goals and objectives ~~shall~~of the Grant program;

c. The Grant availability period;

d. Key Dates, particularly due dates for questions and submission of applications;

e. Total Grant program amount;

f. The minimum and maximum amount of each Grant, if applicable;

g. Specific eligibility requirements;

h. Evaluation criteria;

i. Instructions on submitting applications; and

j. CalOptima Health contact ~~i~~information and communication protocols.

3. CalOptima Health will post the NOFO on its website.

C. Pre-Award: Application Process

1. Upon Board approval of the Grant, CalOptima Health will develop an electronic Grant Application.

2. The electronic Grant Application will be published in ~~alignment with~~the Grants Management system.

3. CalOptima Health may hold a webinar and will publish a frequently asked questions document about the funding opportunity during the application period.

4. Grant Applications will not be accepted after the application period closes.

D. Pre-Award: Grant Application Evaluation and Selection

1. CalOptima Health will select an Evaluation Committee for each NOFO consisting of CalOptima Health employees and, if needed, outside subject matter experts (SMEs).

2. Prior to receiving applications, Grants Management will identify the applicants to each member of the Evaluation Committee. Any person who has a conflict of interest, must inform Grants Management in writing and recuse themselves from further participation in the evaluation

For 20241205 BOD Review Only

process. All persons given access to Grant Applications must document a confidentiality and conflict of interest statement.

3. Grant Applications will first be reviewed for eligibility. Applications that are ineligible will be rejected.

4. The Evaluation Committee will evaluate each Grant Application against the evaluation criteria established in the NOFO.

5. The Evaluation Committee will proceed as follows:

   a. Review each Grant Application and score each application based on the Evaluation Criteria published in the NOFO;

   b. Meet one or more times to discuss their evaluation results during the evaluation period; and

   c. Recommend applicants for Grant Awards based on their scores and funding availability for Board approval.

   ~~a.~~d. An organizational ~~strategic priorities.~~ financial review will be conducted for all or a subset of grant applicants to assess financial solvency.

~~2.~~6. Grant ~~outcomes shall improve or address critical needs of~~ Award recommendations will be submitted for review and approval to the CalOptima Health ~~Members~~Board.

~~Award Grant~~

7. Upon Board approval of one or more Grants, Grant Management will:

   a. Send written notification of their application status to all Grant applicants.

   b. Offer feedback to non-selected applicants if requested.

~~B.~~E. Grant Award: Establishing ~~Goals and Metrics~~Measurable Objectives and Agreement Execution

1. CalOptima Health will ~~work with Grantees to~~ ensure that all Grants have established one or more ~~goals that direct the use of Grant funds~~performance objectives that are measurable and documented in the Grant Agreement. These performance objectives will be the basis for Grant monitoring and reporting.

~~1. CalOptima Health will work with all Grantees to ensure that Grants align with one or more metrics signifying the successful accomplishment of its goal or goals. These metrics will be the basis for monitoring and reporting outcomes and successes.~~

2. CalOptima Health will provide a formal Grant Award letter to the selected Grantee, including applicable templates for Progress Reports, a scope of work, and a Grant payment schedule.

3. Once the necessary documents, including certificate of insurance are obtained, a Grant Agreement will be executed between CalOptima Health and the Grantee.

   a. The Grant Agreement will be sent electronically to the Grantee's point of contact. The document must be signed by an individual who has the authority to legally bind the Grant(s) (Official Signatory).

For 2024 1205 BOD Review Only

Back to Agenda Back to Item

b. The Grantee will be given a sufficient number of days to review the Grant Agreement. CalOptima Health will work with the Grantee to finalize the Grant Agreement.

F. Post-Award: Payment of Grant Fund Disbursements

1. Upon receipt of the fully executed Grant Agreement, CalOptima Health will process payments according to the established payment schedule.

2. CalOptima Health will review Progress Reports, invoices, receipts, and other documentation to determine whether adequate progress has been achieved and that Grant fund expenditures are appropriate before releasing subsequent Grant fund disbursements.

3. Upon completion of the Grant program and closeout review, CalOptima Health will obtain any funds that are found to not have been utilized in accordance with the Grant Agreement.

~~C.~~G. Post-Award: Grant Performance Monitoring and Reporting Requirements

1. CalOptima Health ~~Operations department~~will review Progress Reports and~~/or other internal subject matter experts shall~~ request meetings as needed to monitor ~~a Grantee's~~ compliance and progress towards achieving the ~~goals presented~~objectives in the ~~Grantee's Proposal by reviewing the~~ Grant ~~Progress Reports.~~ Agreement.

~~2.1.~~~~Unless otherwise specified in the Grant contract, Grantees shall~~The Grantee will submit ~~semi-annual Grant~~ Progress Reports based on schedule and frequency indicated in the Grant Agreement to CalOptima Health, detailing ~~Grant~~Grantee activities, along with any required supporting materials through the submission method~~.~~

~~3.~~2. ~~The format and specific details of the Grant Progress Report shall be mutually~~ agreed upon by Grantee and CalOptima Health ~~and the Grantee~~Sponsoring Department.

~~4.~~3. The ~~semi-annual Grant~~ Progress ~~Reports may require~~Report will include a breakdown of funding utilization by category as ~~mutually agreed upon~~required by ~~CalOptima Health and~~ the ~~Grantee~~Grant Agreement.

~~1. CalOptima Health may also utilize Grant Progress Reports to provide updates to CalOptima Health's executives and the CalOptima Health Board about its Grant funding activities.~~

~~2. Grantees shall also submit a final closeout report as stipulated in the Grant contract, summarizing the actions taken by the Grantee over the course of the entire Grant contract term.~~

~~a. The final closeout report will include a breakdown by category of the funds used, and a reconciliation to indicate all funds were used according to the intended purpose.~~

~~5.~~4. ~~As part of CalOptima Health's due diligence, CalOptima Health's designated representative(s) may also elect to~~ conduct site visits to a Grantee's business premises and/or site(s) of Grant-funded service delivery during the Grant ~~contract~~Agreement term for the following actions including, but not limited to:

a. Meet the Grantee's senior leadership, as well as the Grantee's staff or volunteers with primary responsibility for conducting the funded activities;

b. Engage in dialogue with the Grantee about progress toward project milestones and objectives, ~~notable~~ successes, implementation challenges, and early lessons learned;

For 2024 1205 BOD Review Only

Back to Agenda Back to Item

c. Learn of any anticipated requests for scope or budget changes, or no-cost ~~extensions~~extension; and

d. See program services/activities first-hand, if applicable and feasible.

~~6.~~5. Grant payments may be delayed or withheld if site visits and/or Grant Progress Reports reveal ~~Grantees are~~Grantee is not making sufficient progress towards ~~stated~~ goals or ~~are~~is not meeting other Grant ~~contract~~Agreement requirements. CalOptima Health may request that the Grantee realign performance objectives if deemed appropriate.

H. ~~If sufficient progress is not being made toward~~Post Award: Grant ~~contract goals and metrics,~~ Agreement Changes:

1. All Grant Agreement changes must be finalized prior to the expiration of the Grant Agreement.

2. Requests for changes must be received in writing.

3. CalOptima Health will determine whether a requested change is considered a limited change or a material change.

a. Limited Change

i. A limited change to a Grant Agreement does not affect the scope of work ~~with Grantees to understand why metrics were~~ or increase the Grant funding amount requested and is within the grant program parameters approved by the Board of Directors.

ii. A limited change may include but not ~~achieved~~be limited to:

a) A no-cost extension within the same fiscal year;

b) Expenditure shifts between line items in the originally approved budget but within the approved amount; and ~~work with~~

c) Minor resource shifts or changes from the original targeted project plan.

iii. If a requested change is determined to be limited in nature, the change can be approved by the Sponsoring Department.

b. Material Change

i. A material change to a Grant Agreement is a significant change that may include but not be limited to:

a) Significant changes to the targeted activities or outcome(s) funded by the grant award;

b) Any impact to the program schedule or duration causing delay to program implementation that impacts Board-approved funding, i.e. the grant period will extend into a new fiscal year; and

c) A significant reduction in the activities indicated in the Grant Agreement.

For 20241205 BOD Review Only

Back to Agenda Back to Item

ii. If a change is determined to be material in nature, the change must be approved by the Sponsoring Department and the Board of Directors through the COBAR process.

4. If the request is approved, CalOptima Health staff will generate a Grant Agreement amendment document. The document will be sent electronically to the Grantee's point of contact. The document must be signed by the Official Signatory. All signatures on the Grant Agreement amendment must be obtained prior to expiration of the Grant Agreement. Notice of the fully executed Grant Agreement amendment will be sent electronically.

5. If the request is denied, CalOptima Health staff will provide documentation of the denial to the Grantee ~~to realign metrics~~.

I. Post Award: Grant Close-out Procedure

1. At the end of the Grant term, each Grantee will submit a Final Report as outlined in the Grant Agreement, summarizing the activities completed by the Grantee over the course of the entire Grant term, and analyzing its performance against the Grant objectives. The Final Report will include a breakdown by category of the funds used and a reconciliation to indicate all funds were used according to their intended purposes.

2. CalOptima Health will conduct a Grant close-out review that will:

a. Validate that the scope of work and performance objectives of the Grant Agreement were completed;

b. Verify final spending reports and reconcile with Finance;

c. Validate that all required Progress Reports were submitted;

d. Review Final Report for completeness;

e. Retain records for documents, reports, financial documentation, and any other related program artifacts in CalOptima Health SharePoint site; and

~~a.~~f. Conduct a lessons learned review, if ~~deemed appropriate.~~applicable.

3. CalOptima Health shall recoup any unspent grant funds after completion of the project as agreed to in the Grant Agreement.

J. Post Award: Grant Audit

~~7.~~1. CalOptima Health may conduct audits of the ~~Grantee~~Grantee's use of Grant funds and/or of the related CalOptima Health operational areas and financial data during the course of the Grant and/or at the conclusion of the Grant.

a. The audits will be conducted to confirm reported expenditures, performance measures, compliance with key Grant requirements, and other relevant factors as applicable to the specific Grant.

IV. ATTACHMENT(S)

Not Applicable

For 20241205 BOD Review Only

Back to Agenda Back to Item

V. REFERENCE(S)

A. CalOptima Health ~~Strategic Plan~~ Policy AA.1204: Gifts, Honoraria, and Travel Payments
B. CalOptima Health Policy GA.5002: Purchasing
C. CalOptima Health Policy GA.5003: Budget and Operations Forecasting

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/04/2023	AA.1400	Grant Management	Administrative
Revised		AA.1400	Grant Management	Administrative

For 20241205 BOD Review Only

IX. GLOSSARY

Term	Definition
~~Grantee~~Confidential Information	~~A recipient of a grant.~~Any information designated as confidential or which, by its nature, a reasonable person would treat as confidential, given the character of the information and the circumstances of disclosure. It includes all non-public and proprietary information that has been disclosed to or obtained by the recipient from a third party or any other source. CalOptima's Confidential Information also includes all user information, member information, patient information, and clinical data that comes into CalOptima's possession, custody or control.
Covered Person	CalOptima Health employee, officer, Board of Directors (Board) Member, and agent of CalOptima Health.
Evaluation Committee	A Committee of qualified staff and subject matter experts appointed by CalOptima Health to review and assess Grant Applications and program proposals.
Final Report	A document providing information about the Grant project or program's final progress in achieving the goals and objectives of the Grant provided by the Grantee to CalOptima Health. The schedule of submission is set in the Grant Agreement.
~~Grants~~Grant	A financial award given by CalOptima Health to an eligible recipient to achieve a particular purpose or project. Grants are generally not expected to be repaid by the recipient when appropriately used for an approved ~~grant~~Grant project.
Grantee	A recipient of a Grant.
Grant Agreement	A funding agreement between CalOptima Health and the Grantee that sets the terms and conditions of a Grant.
Grant Application	A grant application submitted to CalOptima Health to formally request funding for a specific project.
Grant Award	The dollar amount awarded to the Grantee by CalOptima Health through the Grant Management Policy and Procedure.
Grants Management	CalOptima Health department responsible for overall Grant administration oversight.
Member	A beneficiary enrolled in a CalOptima Health program.
Notice of Funding Opportunity	CalOptima Health's formally issued announcement of the availability of a Board-approved and authorized Grant opportunity through one of its Community Investment programs.
Official Signatory	The designated representative of the applicant or grant recipient organization with authority to act on the organization's behalf in matters related to the award and its administration.
Progress Report	A document providing information about a project or program's progress in achieving the goals and objectives of a Grant.
~~Proposal~~Sponsoring Department	~~An application submitted to CalOptima Health used to formally request funding for a specific project.~~CalOptima Health department responsible for the design and development of Grant program requirements, review of Progress Reports, and review of the Final Report to ensure Grant program objectives and outcomes are achieved.
Strategic Plan	CalOptima Health's strategic priorities, objectives, and action plans.

For 2024 12/5 BOD Review Only

Back to Agenda Back to Item

Policy:	AA.1400
Title:	**Grant Management**
Department:	Strategic Development
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	05/04/2023
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

For 2024 1205 BOD Review Only

I. PURPOSE

This policy outlines the criteria for awarding Grant funds and the expectations of Grantees for discretionary Grant funding disbursed by CalOptima Health.

II. POLICY

A. Ethics

1. General Conduct

   a. Each Covered Person is subject to the Conflict of Interest Laws of the State of California (State) and the CalOptima Health Code of Conduct. Any Covered Person who violates these standards will be subject to the relevant penalties, sanctions, and other disciplinary actions.

2. Gratuities, Kickbacks, and Contingency Fees

   a. Except as allowed under CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments, no Covered Person may solicit or accept any personal gift or anything of value from any person or entity to which a Grant is under consideration for award, has been awarded, or may be awarded, or because of any action taken or to be taken in the performance of the Covered Person's duties. Any Covered Person failing to adhere to the above will be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, up to and including dismissal.

   b. CalOptima Health employees must adhere to all provisions of CalOptima Health Policies AA.1204: Gift, Honoraria, and Travel Payments, and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health.

3. Confidential Information

   a. No Covered Person may use Confidential Information, or information regarding a Grant that has not been made public or become subject to the California Public Records Act, for their actual or anticipated personal gain, or the actual or anticipated personal gain of any other person related to such Covered Person by blood, marriage, or by common commercial or financial interest. A Covered Person failing to adhere to this requirement will be subject

Back to Agenda Back to Item

to any disciplinary proceeding deemed appropriate by CalOptima Health, up to and including dismissal.

b. No Covered Person may divulge Confidential Information to any Grantee, vendor, consultant, or contractor outside the scope of any agreement that may exist with the Grantee, vendor, consultant, or contractor.

c. While a Notice of Funding Opportunity (NOFO) is active, to prevent unfair and inequitable treatment of applicants, no Covered Person may discuss the strengths and weaknesses of an applicant with any other applicants.

4. Personal Conflict of Interest

a. No Covered Person may participate in the selection, award, or administration of an agreement with a Grantee, or in any decision that may have a foreseeable impact on a Grantee if a conflict of interest, real or apparent, exists. Such a conflict arises when a Covered Person, or a Covered Person's spouse, children, or domestic or business partner, has an existing relationship with the applicant, is employed by or has received an offer of employment from the applicant, or is in a position to influence a decision that may result in personal or financial gain to the Covered Person or the Covered Person's spouse, children, or domestic or business partner, as a result of the Grantee's selection or award.

5. Organizational Conflict of Interest

a. Organizational conflicts of interest are circumstances that arise out of a party's business or financial interests, familial relationships, contractual relationships, organizational structure, or existing or past activities, including any prior interactions or work with CalOptima Health, that result or can result in influence on requirements, such as unreleased budgets, scopes of work, selection criteria, or unequal access to information, or the appearance or reality of impropriety or unfair advantage to the party.

b. No person or entity may submit a Grant application if the person or entity has:

i. Directly assisted in drafting or in preparing the specifications, requirements, or cost estimates for that Grant; or

ii. Had access and exposure to information pertinent to that Grant that was unavailable to other potential applicants and would provide a competitive advantage to its possessor.

B. Approach to Grant Management

1. When resources permit, CalOptima Health may designate authorized funds specifically for Board-approved Grant(s) to eligible external organizations.

2. CalOptima Health will ensure the distribution of Grant funds is reflective of CalOptima Health's mission, consistent with CalOptima Health's Strategic Plan, any Board-approved fund allocation plan, and/or any funding source legal parameters and funding restrictions.

3. Each Grant Application will receive a thorough, unbiased evaluation including, but not limited to, an assessment of an organization's experience, capacity, fiscal soundness, benefit to CalOptima Health Members, and feasibility.

For 20241205 BOD Review Only

C. Approvals

1. Funding and funding reallocation for all Grant Awards will be approved by the Board through separate Board actions.

D. Grant Award Funds

1. Grant Award fund disbursements may only be approved by an authorized person pursuant to CalOptima Health's Policy GA.5002: Purchasing.

2. Any person in a position of delegated authority may designate a person of the same level or higher, in writing, to act in their stead when that person is unavailable.

3. Grant fund disbursement approval limits will be consistent with CalOptima Health's Policy GA.5002: Purchasing:

Employee Position	Approval Limit
Manager	$ 1,000
Director	$ 10,000
Executive Director or Officer	$ 100,000
CEO or Chief Operating Officer (COO)	$ Over 100,000

III. PROCEDURE

A. Pre-Award: Grant Authorization Requirements

1. Grants Management will coordinate program development and provide guidance on the grant-making process to initiative owners and/or Sponsoring Department as appropriate.

2. The Sponsoring Department will develop the requirements and criteria for the specific Grant.

3. The Sponsoring Department will develop a NOFO that outlines specific information about the Grant program. Refer to Section III.B. for NOFO requirements.

4. The Sponsoring Department will complete a CalOptima Health Board Action Agenda Referral (COBAR) for Board authorization of the Grant program.

B. Notice of Funding Opportunity (NOFO) Requirements

1. CalOptima Health will issue a NOFO for all Grant programs.

2. At a minimum, each NOFO will contain the following elements:

a. The title of the Grant program;

b. Goals and objectives of the Grant program;

c. The Grant availability period;

d. Key Dates, particularly due dates for questions and submission of applications;

e. Total Grant program amount;

For 20241205 BOD Review Only

Back to Agenda Back to Item

f. The minimum and maximum amount of each Grant, if applicable;

g. Specific eligibility requirements;

h. Evaluation criteria;

i. Instructions on submitting applications; and

j. CalOptima Health contact information and communication protocols.

3. CalOptima Health will post the NOFO on its website.

C. Pre-Award: Application Process

1. Upon Board approval of the Grant, CalOptima Health will develop an electronic Grant Application.

2. The electronic Grant Application will be published in the Grants Management system.

3. CalOptima Health may hold a webinar and will publish a frequently asked questions document about the funding opportunity during the application period.

4. Grant Applications will not be accepted after the application period closes.

D. Pre-Award: Grant Application Evaluation and Selection

1. CalOptima Health will select an Evaluation Committee for each NOFO consisting of CalOptima Health employees and, if needed, outside subject matter experts (SMEs).

2. Prior to receiving applications, Grants Management will identify the applicants to each member of the Evaluation Committee. Any person who has a conflict of interest, must inform Grants Management in writing and recuse themselves from further participation in the evaluation process. All persons given access to Grant Applications must document a confidentiality and conflict of interest statement.

3. Grant Applications will first be reviewed for eligibility. Applications that are ineligible will be rejected.

4. The Evaluation Committee will evaluate each Grant Application against the evaluation criteria established in the NOFO.

5. The Evaluation Committee will proceed as follows:

a. Review each Grant Application and score each application based on the Evaluation Criteria published in the NOFO;

b. Meet one or more times to discuss their evaluation results during the evaluation period; and

c. Recommend applicants for Grant Awards based on their scores and funding availability for Board approval.

d. An organizational financial review will be conducted for all or a subset of grant applicants to assess financial solvency.

For 20241205 BOD Review Only

Back to Agenda Back to Item

6. Grant Award recommendations will be submitted for review and approval to the CalOptima Health Board.

7. Upon Board approval of one or more Grants, Grant Management will:

   a. Send written notification of their application status to all Grant applicants.

   b. Offer feedback to non-selected applicants if requested.

E. Grant Award: Establishing Measurable Objectives and Agreement Execution

1. CalOptima Health will ensure that all Grants have established one or more performance objectives that are measurable and documented in the Grant Agreement. These performance objectives will be the basis for Grant monitoring and reporting.

2. CalOptima Health will provide a formal Grant Award letter to the selected Grantee, including applicable templates for Progress Reports, a scope of work, and a Grant payment schedule.

3. Once the necessary documents, including certificate of insurance are obtained, a Grant Agreement will be executed between CalOptima Health and the Grantee.

   a. The Grant Agreement will be sent electronically to the Grantee's point of contact. The document must be signed by an individual who has the authority to legally bind the Grant(s) (Official Signatory).

   b. The Grantee will be given a sufficient number of days to review the Grant Agreement. CalOptima Health will work with the Grantee to finalize the Grant Agreement.

F. Post-Award: Payment of Grant Fund Disbursements

1. Upon receipt of the fully executed Grant Agreement, CalOptima Health will process payments according to the established payment schedule.

2. CalOptima Health will review Progress Reports, invoices, receipts, and other documentation to determine whether adequate progress has been achieved and that Grant fund expenditures are appropriate before releasing subsequent Grant fund disbursements.

3. Upon completion of the Grant program and closeout review, CalOptima Health will obtain any funds that are found to not have been utilized in accordance with the Grant Agreement.

G. Post-Award: Grant Performance Monitoring and Reporting Requirements

1. CalOptima Health will review Progress Reports and request meetings as needed to monitor compliance and progress towards achieving the objectives in the Grant Agreement.

2. The Grantee will submit Progress Reports based on schedule and frequency indicated in the Grant Agreement to CalOptima Health, detailing Grantee activities, along with any required supporting materials through the submission method agreed upon by Grantee and CalOptima Health Sponsoring Department.

3. The Progress Report will include a breakdown of funding utilization by category as required by the Grant Agreement.

For 20241205 BOD Review Only

4. CalOptima Health may conduct site visits to a Grantee's business premises and/or site(s) of Grant- funded service delivery during the Grant Agreement term for the following actions including, but not limited to:

    a. Meet the Grantee's senior leadership, as well as the Grantee's staff or volunteers with primary responsibility for conducting the funded activities;

    b. Engage in dialogue with the Grantee about progress toward project milestones and objectives, successes, implementation challenges, and early lessons learned;

    c. Learn of any anticipated requests for scope or budget changes, or no-cost extension; and

    d. See program services/activities first-hand, if applicable and feasible.

5. Grant payments may be delayed or withheld if site visits and/or Grant Progress Reports reveal Grantee is not making sufficient progress towards goals or is not meeting other Grant Agreement requirements. CalOptima Health may request that the Grantee realign performance objectives if deemed appropriate.

H. Post Award: Grant Agreement Changes:

1. All Grant Agreement changes must be finalized prior to the expiration of the Grant Agreement.

2. Requests for changes must be received in writing.

3. CalOptima Health will determine whether a requested change is considered a limited change or a material change.

    a. Limited Change

        i. A limited change to a Grant Agreement does not affect the scope of work or increase the Grant funding amount requested and is within the grant program parameters approved by the Board of Directors.

        ii. A limited change may include but not be limited to:

            a) A no-cost extension within the same fiscal year;

            b) Expenditure shifts between line items in the originally approved budget but within the approved amount; and

            c) Minor resource shifts or changes from the original targeted project plan.

        iii. If a requested change is determined to be limited in nature, the change can be approved by the Sponsoring Department.

    b. Material Change

        i. A material change to a Grant Agreement is a significant change that may include but not be limited to:

For 20241205 BOD Review Only

a) Significant changes to the targeted activities or outcome(s) funded by the grant award;

b) Any impact to the program schedule or duration causing delay to program implementation that impacts Board-approved funding, i.e. the grant period will extend into a new fiscal year; and

c) A significant reduction in the activities indicated in the Grant Agreement.

ii. If a change is determined to be material in nature, the change must be approved by the Sponsoring Department and the Board of Directors through the COBAR process.

4. If the request is approved, CalOptima Health staff will generate a Grant Agreement amendment document. The document will be sent electronically to the Grantee's point of contact. The document must be signed by the Official Signatory. All signatures on the Grant Agreement amendment must be obtained prior to expiration of the Grant Agreement. Notice of the fully executed Grant Agreement amendment will be sent electronically.

5. If the request is denied, CalOptima Health staff will provide documentation of the denial to the Grantee.

I. Post Award: Grant Close-out Procedure

1. At the end of the Grant term, each Grantee will submit a Final Report as outlined in the Grant Agreement, summarizing the activities completed by the Grantee over the course of the entire Grant term, and analyzing its performance against the Grant objectives. The Final Report will include a breakdown by category of the funds used and a reconciliation to indicate all funds were used according to their intended purposes.

2. CalOptima Health will conduct a Grant close-out review that will:

a. Validate that the scope of work and performance objectives of the Grant Agreement were completed;

b. Verify final spending reports and reconcile with Finance;

c. Validate that all required Progress Reports were submitted;

d. Review Final Report for completeness;

e. Retain records for documents, reports, financial documentation, and any other related program artifacts in CalOptima Health SharePoint site; and

f. Conduct a lessons learned review, if applicable.

3. CalOptima Health shall recoup any unspent grant funds after completion of the project as agreed to in the Grant Agreement.

J. Post Award: Grant Audit

1. CalOptima Health may conduct audits of the Grantee's use of Grant funds and/or of the related CalOptima Health operational areas and financial data during the course of the Grant and/or at the conclusion of the Grant.

For 20241205 BOD Review Only

Back to Agenda Back to Item

a. The audits will be conducted to confirm reported expenditures, performance measures, compliance with key Grant requirements, and other relevant factors as applicable to the specific Grant.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
B. CalOptima Health Policy GA.5002: Purchasing
C. CalOptima Health Policy GA.5003: Budget and Operations Forecasting

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/04/2023	AA.1400	Grant Management	Administrative
Revised		AA.1400	Grant Management	Administrative

For 20241205 BOD Review Only

Back to Agenda Back to Item

IX. GLOSSARY

Term	Definition
Confidential Information	Any information designated as confidential or which, by its nature, a reasonable person would treat as confidential, given the character of the information and the circumstances of disclosure. It includes all non-public and proprietary information that has been disclosed to or obtained by the recipient from a third party or any other source. CalOptima's Confidential Information also includes all user information, member information, patient information, and clinical data that comes into CalOptima's possession, custody or control.
Covered Person	CalOptima Health employee, officer, Board of Directors (Board) Member, and agent of CalOptima Health.
Evaluation Committee	A Committee of qualified staff and subject matter experts appointed by CalOptima Health to review and assess Grant Applications and program proposals.
Final Report	A document providing information about the Grant project or program's final progress in achieving the goals and objectives of the Grant provided by the Grantee to CalOptima Health. The schedule of submission is set in the Grant Agreement.
Grant	A financial award given by CalOptima Health to an eligible recipient to achieve a particular purpose or project. Grants are generally not expected to be repaid by the recipient when appropriately used for an approved Grant project.
Grantee	A recipient of a Grant.
Grant Agreement	A funding agreement between CalOptima Health and the Grantee that sets the terms and conditions of a Grant.
Grant Application	A grant application submitted to CalOptima Health to formally request funding for a specific project.
Grant Award	The dollar amount awarded to the Grantee by CalOptima Health through the Grant Management Policy and Procedure.
Grants Management	CalOptima Health department responsible for overall Grant administration oversight.
Member	A beneficiary enrolled in a CalOptima Health program.
Notice of Funding Opportunity	CalOptima Health's formally issued announcement of the availability of a Board-approved and authorized Grant opportunity through one of its Community Investment programs.
Official Signatory	The designated representative of the applicant or grant recipient organization with authority to act on the organization's behalf in matters related to the award and its administration.
Progress Report	A document providing information about a project or program's progress in achieving the goals and objectives of a Grant.
Sponsoring Department	CalOptima Health department responsible for the design and development of Grant program requirements, review of Progress Reports, and review of the Final Report to ensure Grant program objectives and outcomes are achieved.
Strategic Plan	CalOptima Health's strategic priorities, objectives, and action plans.

For 2024 1205 BOD Review Only

Policy:	AA.1400
Title:	**Grant Management**
Department:	~~Strategic Development~~Medi-Cal & CalAIM
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	05/04/2023
Revised Date:	TBD
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE ~~☒ Administrative~~

For 20250807 BOD Review Only

I. PURPOSE

This policy outlines the criteria for awarding Grant funds and the expectations of Grantees for discretionary Grant funding disbursed by CalOptima Health. Quality incentive pay for value programs are excluded from this policy.

For the purpose of this policy, the key distinctions between a grant and a service contract are as follows:

Grant: A financial award given by CalOptima Health to an eligible recipient to achieve a particular purpose or project. Grants are generally not expected to be repaid by the recipient when appropriately used for an approved Grant project.

Service Contract: A service contract is a commercial agreement to procure specific goods or services, under which the contractor agrees to deliver the specified goods or services in exchange for a fixed fee, hourly rate, or per-deliverable price, which may include profit or markup above actual cost.

II. POLICY

A. Ethics

1. General Conduct

a. Each Covered Person is subject to the Conflict of Interest Laws of the State of California (State) and the CalOptima Health Code of Conduct. Any Covered Person who violates these standards will be subject to the relevant penalties, sanctions, and other disciplinary actions.

2. Gratuities, Kickbacks, and Contingency Fees

a. Except as allowed under CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments, no Covered Person may solicit or accept any personal gift or anything of value from any person or entity to which a Grant is under consideration for award, has been awarded, or may be awarded, or because of any action taken or to be taken in the performance of the Covered Person's duties. Any Covered Person failing to adhere to the

Back to Agenda Back to Item

above will be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, up to and including dismissal.

b. CalOptima Health employees must adhere to all provisions of CalOptima Health Policies AA.1204: Gift, Honoraria, and Travel Payments, and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health.

3. Confidential Information

a. No Covered Person may use Confidential Information, or information regarding a Grant that has not been made public or become subject to the California Public Records Act, for their actual or anticipated personal gain, or the actual or anticipated personal gain of any other person related to such Covered Person by blood, marriage, or by common commercial or financial interest. A Covered Person failing to adhere to this requirement will be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, up to and including dismissal.

b. No Covered Person may divulge Confidential Information to any Grantee, vendor, consultant, or contractor outside the scope of any agreement that may exist with the Grantee, vendor, consultant, or contractor.

c. While a Notice of Funding Opportunity (NOFO) is active, to prevent unfair and inequitable treatment of applicants, no Covered Person may discuss the strengths and weaknesses of an applicant with any other applicants.

4. Personal Conflict of Interest

a. No Covered Person may participate in the selection, award, or administration of an agreement with a Grantee, or in any decision that may have a foreseeable impact on a Grantee if a conflict of interest, real or apparent, exists. Such a conflict arises when a Covered Person, or a Covered Person's spouse, children, or domestic or business partner, has an existing relationship with the applicant, is employed by or has received an offer of employment from the applicant, or is in a position to influence a decision that may result in personal or financial gain to the Covered Person or the Covered Person's spouse, children, or domestic or business partner, as a result of the Grantee's selection or award.

5. Organizational Conflict of Interest

a. Organizational conflicts of interest are circumstances that arise out of a party's business or financial interests, familial relationships, contractual relationships, organizational structure, or existing or past activities, including any prior interactions or work with CalOptima Health, that result or can result in influence on requirements, such as unreleased budgets, scopes of work, selection criteria, or unequal access to information, or the appearance or reality of impropriety or unfair advantage to the party.

b. No person or entity may submit a Grant ~~application~~Application if the person or entity ~~has~~:

i. ~~Directly~~Has directly assisted in drafting or in preparing the specifications, requirements, or cost estimates for that Grant; ~~or~~

ii. Had access and exposure to information pertinent to that Grant that was unavailable to other potential applicants and would provide a competitive advantage to its possessor~~.~~;

DRAFT
For 20250807 BOD Review Only

iii. Is not a registered tax-exempt 501(c)3 nonprofit organization, or a governmental body, or a municipality, or a registered educational institution or tribal entity;

iv. Is not in good standing with the Secretary of State as a 501(c)3;

v. Has an active grant with a duplicative Scope of Work or budget with CalOptima Health, where being a sub-awardee does not apply; or

vi. Is not in good standing with CalOptima Health, good standing being defined by:

a) Having closed all previous grant awards as indicated by a close out letter from CalOptima Health;

b) Having no active investigations or corrective actions with CalOptima Health; and

c) Having no open investigations or legal proceedings with any federal agencies.

B. Approach to Grant Management

1. When resources permit, CalOptima Health may designate authorized funds specifically for Board-approved Grant(s) to eligible external organizations.

2. CalOptima Health will ensure the distribution of Grant funds is reflective of CalOptima Health's mission, consistent with CalOptima Health's Strategic Plan, any Board-approved fund allocation plan, and/or any funding source legal parameters and funding restrictions.

3. Each Grant Application will receive a thorough, unbiased evaluation including, but not limited to, an assessment of an organization's experience, capacity, fiscal soundness, benefit to CalOptima Health Members, and feasibility.

4. CalOptima Health will review the Board of Directors composition of each grant applicant for potential conflicts of interest and advise the CalOptima Health Board of Directors accordingly;

C. Approvals

1. Funding and funding reallocation for all Grant Awards will be approved by the Board through separate Board actions.

D. Grant Award Funds

1. When funding opportunities allow for indirect expenses in the requested budget, CalOptima Health will allow a standard indirect cost rate not to exceed fifteen percent (15%) only applicable to personnel, salary, and benefit expenses.

~~1.~~2. Grant Award fund disbursements may only be approved by an authorized person pursuant to CalOptima Health's Policy GA.5002: Purchasing.

~~2.~~3. Any person in a position of delegated authority may designate a person of the same level or higher, in writing, to act in their stead when that person is unavailable.

~~3.~~4. Grant fund disbursement approval limits will be consistent with CalOptima Health's Policy GA.5002: Purchasing:

DRAFT For 20250807 BOD Review Only

Back to Agenda Back to Item

Employee Position	Approval Limit
Manager	$ 1,000
Director	$ 10,000
Executive Director or Officer	$ 100,000
CEO or Chief Operating Officer (COO)	$ Over 100,000

III. PROCEDURE

A. Pre-Award: Grant Authorization Requirements

1. Grants Management will coordinate program development and provide guidance on the grant-making process to initiative owners and/or Sponsoring Department as appropriate.

2. The Sponsoring Department will develop the requirements and criteria for the specific Grant.

3. The Sponsoring Department will develop a NOFO that outlines specific information about the Grant program. Refer to Section III.B. for NOFO requirements.

4. The Sponsoring Department will complete a CalOptima Health Board Action Agenda Referral (COBAR) for Board authorization of the Grant program.

B. Notice of Funding Opportunity (NOFO) Requirements

1. CalOptima Health will issue a NOFO for all Grant programs.

2. At a minimum, each NOFO will contain the following elements:

a. The title of the Grant program;

b. Goals and objectives of the Grant program;

c. The Grant availability period;

d. Key Dates, particularly due dates for questions and submission of applications;

e. Total Grant program amount;

f. The minimum and maximum amount of each Grant, if applicable;

g. Specific eligibility requirements;

h. Evaluation criteria;

i. Instructions on submitting applications; and

j. CalOptima Health contact information and communication protocols.

DRAFT
For 20250807 BOD Review Only

3. CalOptima Health will post the NOFO on its website.

C. Pre-Award: Application Process

1. Upon Board approval of the Grant, CalOptima Health will develop an electronic Grant Application.

2. The electronic Grant Application will be published in the Grants Management system.

3. CalOptima Health may hold a webinar and will publish a frequently asked questions document about the funding opportunity during the application period.

4. Grant Applications will not be accepted after the application period closes.

D. Pre-Award: Grant Application Evaluation and Selection

1. CalOptima Health will select an Evaluation Committee for each NOFO consisting of CalOptima Health employees and, if needed, outside subject matter experts (SMEs).

2. Prior to receiving applications, Grants Management will identify the applicants to each member of the Evaluation Committee. Any person who has a conflict of interest, must inform Grants Management in writing and recuse themselves from further participation in the evaluation process. All persons given access to Grant Applications must document a confidentiality and conflict of interest statement.

3. Grant Applications will first be reviewed for eligibility. Applications that are ineligible will be rejected.

4. The Evaluation Committee will evaluate each Grant Application against the evaluation criteria established in the NOFO.

5. The Evaluation Committee will proceed as follows:

   a. Review each Grant Application and score each application based on the Evaluation Criteria published in the NOFO;

   b. Meet one or more times to discuss their evaluation results during the evaluation period; and

   c. Recommend applicants for Grant Awards based on their scores and funding availability for Board approval.

   d. An organizational financial review will be conducted for all or a subset of grant applicants to assess financial solvency.

6. Grant Award recommendations will be submitted for review and approval to the CalOptima Health Board.

7. Upon Board approval of one or more Grants, Grant Management will:

   a. Send written notification of their application status to all Grant applicants.

   b. Offer feedback to non-selected applicants if requested.

DRAFT
For 20250807 BOD Review Only

E. Grant Award: Establishing Measurable Objectives and Agreement Execution

1. CalOptima Health will ensure that all Grants have established one or more performance objectives that are measurable and documented in the Grant Agreement. These performance objectives will be the basis for Grant monitoring and reporting.

2. CalOptima Health will provide a formal Grant Award letter to the selected Grantee, including applicable templates for Progress Reports, a scope of work, and a Grant payment schedule.

3. Once the necessary documents, including certificate of insurance are obtained, a Grant Agreement will be executed between CalOptima Health and the Grantee.

   a. The Grant Agreement will be sent electronically to the Grantee's point of contact. The document must be signed by an individual who has the authority to legally bind the Grant(s) (Official Signatory).

   b. The Grantee will be given a sufficient number of days to review the Grant Agreement. CalOptima Health will work with the Grantee to finalize the Grant Agreement.

F. Post-Award: Payment of Grant Fund Disbursements

1. Upon receipt of the fully executed Grant Agreement, CalOptima Health will process payments according to the established payment schedule.

2. CalOptima Health will review Progress Reports, invoices, receipts, and other documentation to determine whether adequate progress toward program objectives and fund expenditure has been achieved and that Grant fund expenditures are appropriate before releasing subsequent Grant fund disbursements.

3. Upon completion of the Grant program and closeout review, CalOptima Health will obtain any funds that are found to not have been utilized in accordance with the Grant Agreement.

G. Post-Award: Grant Performance Monitoring and Reporting Requirements

1. CalOptima Health will review Progress Reports and request meetings as needed to monitor compliance and progress towards achieving the objectives in the Grant Agreement.

2. The Grantee will submit Progress Reports based on schedule and frequency indicated in the Grant Agreement to CalOptima Health, detailing Grantee activities, along with any required supporting materials through the submission method agreed upon by Grantee and CalOptima Health Sponsoring Department.

3. The Progress Report will include a breakdown of funding utilization by category as required by the Grant Agreement.

4. CalOptima Health may conduct site visits to a Grantee's business premises and/or site(s) of Grant- funded service delivery during the Grant Agreement term for the following actions including, but not limited to:

   a. Meet the Grantee's senior leadership, as well as the Grantee's staff or volunteers with primary responsibility for conducting the funded activities;

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b. Engage in dialogue with the Grantee about progress toward project milestones and objectives, successes, implementation challenges, and early lessons learned;

c. Learn of any anticipated requests for scope or budget changes, or no-cost extension; and

d. See program services/activities first-hand, if applicable and feasible.

5. Grant payments may be delayed or withheld if site visits and/or Grant Progress Reports reveal Grantee is not making sufficient progress towards goals, is not expending released funds in a timely manner, or is not meeting other Grant Agreement requirements. CalOptima Health may request that the Grantee realign performance objectives if deemed appropriate.

6. The Grantee will submit an electronic copy of their annual independent audit each year within thirty (30) days of its completion.

H. Post Award: Grant Agreement Changes:

1. All Grant Agreement changes must be finalized prior to the expiration of the Grant Agreement.

2. Requests for changes must be received in writing.

3. CalOptima Health will determine whether a requested change is considered a limited change or a material change.

a. Limited Change

i. A limited change to a Grant Agreement does not affect the scope of work or increase the Grant funding amount requested and is within the grant program parameters approved by the Board of Directors.

ii. A limited change may include but not be limited to:

a) A no-cost extension within the same fiscal year;

b) Expenditure shifts between line items in the originally approved budget but within the approved amount; and

c) Minor resource shifts or changes from the original targeted project plan.

iii. If a requested change is determined to be limited in nature, the change can be approved by the Sponsoring Department.

b. Material Change

i. A material change to a Grant Agreement is a significant change that may include but not be limited to:

a) Significant changes to the targeted activities or outcome(s) funded by the grant award;

b) Any impact to the program schedule or duration causing delay to program implementation that impacts Board-approved funding, i.e. the grant period will extend into a new fiscal year; and

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For 20250807 POD Review Only

c) A significant reduction in the activities indicated in the Grant Agreement.

ii. If a change is determined to be material in nature, the change must be approved by the Sponsoring Department and the Board of Directors through the COBAR process.

4. If the request is approved, CalOptima Health staff will generate a Grant Agreement amendment document. The document will be sent electronically to the Grantee's point of contact. The document must be signed by the Official Signatory. All signatures on the Grant Agreement amendment must be obtained prior to expiration of the Grant Agreement. Notice of the fully executed Grant Agreement amendment will be sent electronically.

5. If the request is denied, CalOptima Health staff will provide documentation of the denial to the Grantee.

I. Post Award: Grant Close-out Procedure

1. At the end of the Grant term, each Grantee will submit a Final Report as outlined in the Grant Agreement, summarizing the activities completed by the Grantee over the course of the entire Grant term, and analyzing its performance against the Grant objectives. The Final Report will include a breakdown by category of the funds used and a reconciliation to indicate all funds were used according to their intended purposes.

2. CalOptima Health will conduct a Grant close-out review that will:

a. Validate that the scope of work and performance objectives of the Grant Agreement were completed;

b. Verify final spending reports and reconcile with Finance;

c. Validate that all required Progress Reports were submitted;

d. Review Final Report for completeness;

e. Retain records for documents, reports, financial documentation, and any other related program artifacts in CalOptima Health SharePoint site; and

f. Conduct a lessons learned review, if applicable.

3. CalOptima Health shall recoup any unspent grant funds after completion of the project as agreed to in the Grant Agreement.

J. Post Award: Grant Audit

1. CalOptima Health may conduct audits of the Grantee's use of Grant funds and/or of the related CalOptima Health operational areas and financial data during the course of the Grant and/or at the conclusion of the Grant.

a. The audits will be conducted to confirm reported expenditures, performance measures, compliance with key Grant requirements, and other relevant factors as applicable to the specific Grant.

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For 20250807 BOD Review Only

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
B. CalOptima Health Policy GA.5002: Purchasing
~~C. CalOptima Health Policy GA.5003: Budget and Operations Forecasting~~

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/04/2023	AA.1400	Grant Management	Administrative
Revised	12/05/2024	AA.1400	Grant Management	Administrative
Revised	TBD	AA.1400	Grant Management	Administrative

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IX. GLOSSARY

Term	Definition
Confidential Information	Any information designated as confidential or which, by its nature, a reasonable person would treat as confidential, given the character of the information and the circumstances of disclosure. It includes all non-public and proprietary information that has been disclosed to or obtained by the recipient from a third party or any other source. CalOptima's Confidential Information also includes all user information, ~~member~~Member information, patient information, and clinical data that comes into CalOptima's possession, custody or control.
Covered Person	CalOptima Health employee, officer, Board of Directors (Board) Member, and agent of CalOptima Health.
Evaluation Committee	A Committee of qualified staff and subject matter experts appointed by CalOptima Health to review and assess Grant Applications and program proposals.
Final Report	A document providing information about the Grant project or program's final progress in achieving the goals and objectives of the Grant provided by the Grantee to CalOptima Health. The schedule of submission is set in the Grant Agreement.
Grant	A financial award given by CalOptima Health to an eligible recipient to achieve a particular purpose or project. Grants are generally not expected to be repaid by the recipient when appropriately used for an approved Grant project.
Grantee	A recipient of a Grant.
Grant Agreement	A funding agreement between CalOptima Health and the Grantee that sets the terms and conditions of a Grant.
Grant Application	A grant application submitted to CalOptima Health to formally request funding for a specific project.
Grant Award	The dollar amount awarded to the Grantee by CalOptima Health through the Grant Management Policy and Procedure.
Grants Management	CalOptima Health department responsible for overall Grant administration oversight.
Member	A beneficiary enrolled in a CalOptima Health program.
Notice of Funding Opportunity (NOFO)	CalOptima Health's formally issued announcement of the availability of a Board-approved and authorized Grant opportunity through one of its Community Investment programs.
Official Signatory	The designated representative of the applicant or grant recipient organization with authority to act on the organization's behalf in matters related to the award and its administration.
Progress Report	A document providing information about a project or program's progress in achieving the goals and objectives of a Grant.
Sponsoring Department	CalOptima Health department responsible for the design and development of Grant program requirements, review of Progress Reports, and review of the Final Report to ensure Grant program objectives and outcomes are achieved.
Strategic Plan	CalOptima Health's strategic priorities, objectives, and action plans.

DRAFT
For 20250807 BOD Review Only

Back to Agenda Back to Item

Policy:	AA.1400
Title:	**Grant Management**
Department:	Medi-Cal & CalAIM
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	05/04/2023
Revised Date:	TBD
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250807 BOD Review Only

I. PURPOSE

This policy outlines the criteria for awarding Grant funds and the expectations of Grantees for discretionary Grant funding disbursed by CalOptima Health. Quality incentive pay for value programs are excluded from this policy.

For the purpose of this policy, the key distinctions between a grant and a service contract are as follows:

Grant: A financial award given by CalOptima Health to an eligible recipient to achieve a particular purpose or project. Grants are generally not expected to be repaid by the recipient when appropriately used for an approved Grant project.

Service Contract: A service contract is a commercial agreement to procure specific goods or services, under which the contractor agrees to deliver the specified goods or services in exchange for a fixed fee, hourly rate, or per-deliverable price, which may include profit or markup above actual cost.

II. POLICY

A. Ethics

1. General Conduct

a. Each Covered Person is subject to the Conflict of Interest Laws of the State of California (State) and the CalOptima Health Code of Conduct. Any Covered Person who violates these standards will be subject to the relevant penalties, sanctions, and other disciplinary actions.

2. Gratuities, Kickbacks, and Contingency Fees

a. Except as allowed under CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments, no Covered Person may solicit or accept any personal gift or anything of value from any person or entity to which a Grant is under consideration for award, has been awarded, or may be awarded, or because of any action taken or to be taken in the performance of the Covered Person's duties. Any Covered Person failing to adhere to the

Back to Agenda Back to Item

above will be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, up to and including dismissal.

b. CalOptima Health employees must adhere to all provisions of CalOptima Health Policies AA.1204: Gift, Honoraria, and Travel Payments, and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health.

3. Confidential Information

a. No Covered Person may use Confidential Information, or information regarding a Grant that has not been made public or become subject to the California Public Records Act, for their actual or anticipated personal gain, or the actual or anticipated personal gain of any other person related to such Covered Person by blood, marriage, or by common commercial or financial interest. A Covered Person failing to adhere to this requirement will be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, up to and including dismissal.

b. No Covered Person may divulge Confidential Information to any Grantee, vendor, consultant, or contractor outside the scope of any agreement that may exist with the Grantee, vendor, consultant, or contractor.

c. While a Notice of Funding Opportunity (NOFO) is active, to prevent unfair and inequitable treatment of applicants, no Covered Person may discuss the strengths and weaknesses of an applicant with any other applicants.

4. Personal Conflict of Interest

a. No Covered Person may participate in the selection, award, or administration of an agreement with a Grantee, or in any decision that may have a foreseeable impact on a Grantee if a conflict of interest, real or apparent, exists. Such a conflict arises when a Covered Person, or a Covered Person's spouse, children, or domestic or business partner, has an existing relationship with the applicant, is employed by or has received an offer of employment from the applicant, or is in a position to influence a decision that may result in personal or financial gain to the Covered Person or the Covered Person's spouse, children, or domestic or business partner, as a result of the Grantee's selection or award.

5. Organizational Conflict of Interest

a. Organizational conflicts of interest are circumstances that arise out of a party's business or financial interests, familial relationships, contractual relationships, organizational structure, or existing or past activities, including any prior interactions or work with CalOptima Health, that result or can result in influence on requirements, such as unreleased budgets, scopes of work, selection criteria, or unequal access to information, or the appearance or reality of impropriety or unfair advantage to the party.

b. No person or entity may submit a Grant Application if the person or entity:

i. Has directly assisted in drafting or in preparing the specifications, requirements, or cost estimates for that Grant;

ii. Had access and exposure to information pertinent to that Grant that was unavailable to other potential applicants and would provide a competitive advantage to its possessor;

For 20250807 BOD Review Only

iii. Is not a registered tax-exempt 501(c)3 nonprofit organization, or a governmental body, or a municipality, or a registered educational institution or tribal entity;

iv. Is not in good standing with the Secretary of State as a 501(c)3;

v. Has an active grant with a duplicative Scope of Work or budget with CalOptima Health, where being a sub-awardee does not apply; or

vi. Is not in good standing with CalOptima Health, good standing being defined by:

a) Having closed all previous grant awards as indicated by a close out letter from CalOptima Health;

b) Having no active investigations or corrective actions with CalOptima Health; and

c) Having no open investigations or legal proceedings with any federal agencies.

B. Approach to Grant Management

1. When resources permit, CalOptima Health may designate authorized funds specifically for Board-approved Grant(s) to eligible external organizations.

2. CalOptima Health will ensure the distribution of Grant funds is reflective of CalOptima Health's mission, consistent with CalOptima Health's Strategic Plan, any Board-approved fund allocation plan, and/or any funding source legal parameters and funding restrictions.

3. Each Grant Application will receive a thorough, unbiased evaluation including, but not limited to, an assessment of an organization's experience, capacity, fiscal soundness, benefit to CalOptima Health Members, and feasibility.

4. CalOptima Health will review the Board of Directors composition of each grant applicant for potential conflicts of interest and advise the CalOptima Health Board of Directors accordingly;

C. Approvals

1. Funding and funding reallocation for all Grant Awards will be approved by the Board through separate Board actions.

D. Grant Award Funds

1. When funding opportunities allow for indirect expenses in the requested budget, CalOptima Health will allow a standard indirect cost rate not to exceed fifteen percent (15%) only applicable to personnel, salary, and benefit expenses.

2. Grant Award fund disbursements may only be approved by an authorized person pursuant to CalOptima Health's Policy GA.5002: Purchasing.

3. Any person in a position of delegated authority may designate a person of the same level or higher, in writing, to act in their stead when that person is unavailable.

4. Grant fund disbursement approval limits will be consistent with CalOptima Health's Policy GA.5002: Purchasing:

For 20250807 BOD Review Only

Back to Agenda Back to Item

Employee Position	Approval Limit
Manager	$ 1,000
Director	$ 10,000
Executive Director or Officer	$ 100,000
CEO or Chief Operating Officer (COO)	$ Over 100,000

III. PROCEDURE

A. Pre-Award: Grant Authorization Requirements

1. Grants Management will coordinate program development and provide guidance on the grant-making process to initiative owners and/or Sponsoring Department as appropriate.

2. The Sponsoring Department will develop the requirements and criteria for the specific Grant.

3. The Sponsoring Department will develop a NOFO that outlines specific information about the Grant program. Refer to Section III.B. for NOFO requirements.

4. The Sponsoring Department will complete a CalOptima Health Board Action Agenda Referral (COBAR) for Board authorization of the Grant program.

B. Notice of Funding Opportunity (NOFO) Requirements

1. CalOptima Health will issue a NOFO for all Grant programs.

2. At a minimum, each NOFO will contain the following elements:

   a. The title of the Grant program;

   b. Goals and objectives of the Grant program;

   c. The Grant availability period;

   d. Key Dates, particularly due dates for questions and submission of applications;

   e. Total Grant program amount;

   f. The minimum and maximum amount of each Grant, if applicable;

   g. Specific eligibility requirements;

   h. Evaluation criteria;

   i. Instructions on submitting applications; and

   j. CalOptima Health contact information and communication protocols.

For 20250807 BOD Review Only

Back to Agenda Back to Item

3. CalOptima Health will post the NOFO on its website.

C. Pre-Award: Application Process

1. Upon Board approval of the Grant, CalOptima Health will develop an electronic Grant Application.

2. The electronic Grant Application will be published in the Grants Management system.

3. CalOptima Health may hold a webinar and will publish a frequently asked questions document about the funding opportunity during the application period.

4. Grant Applications will not be accepted after the application period closes.

D. Pre-Award: Grant Application Evaluation and Selection

1. CalOptima Health will select an Evaluation Committee for each NOFO consisting of CalOptima Health employees and, if needed, outside subject matter experts (SMEs).

2. Prior to receiving applications, Grants Management will identify the applicants to each member of the Evaluation Committee. Any person who has a conflict of interest, must inform Grants Management in writing and recuse themselves from further participation in the evaluation process. All persons given access to Grant Applications must document a confidentiality and conflict of interest statement.

3. Grant Applications will first be reviewed for eligibility. Applications that are ineligible will be rejected.

4. The Evaluation Committee will evaluate each Grant Application against the evaluation criteria established in the NOFO.

5. The Evaluation Committee will proceed as follows:

   a. Review each Grant Application and score each application based on the Evaluation Criteria published in the NOFO;

   b. Meet one or more times to discuss their evaluation results during the evaluation period; and

   c. Recommend applicants for Grant Awards based on their scores and funding availability for Board approval.

   d. An organizational financial review will be conducted for all or a subset of grant applicants to assess financial solvency.

6. Grant Award recommendations will be submitted for review and approval to the CalOptima Health Board.

7. Upon Board approval of one or more Grants, Grant Management will:

   a. Send written notification of their application status to all Grant applicants.

   b. Offer feedback to non-selected applicants if requested.

For 20250807 BOD Review Only

Back to Agenda Back to Item

E. Grant Award: Establishing Measurable Objectives and Agreement Execution

1. CalOptima Health will ensure that all Grants have established one or more performance objectives that are measurable and documented in the Grant Agreement. These performance objectives will be the basis for Grant monitoring and reporting.

2. CalOptima Health will provide a formal Grant Award letter to the selected Grantee, including applicable templates for Progress Reports, a scope of work, and a Grant payment schedule.

3. Once the necessary documents, including certificate of insurance are obtained, a Grant Agreement will be executed between CalOptima Health and the Grantee.

    a. The Grant Agreement will be sent electronically to the Grantee's point of contact. The document must be signed by an individual who has the authority to legally bind the Grant(s) (Official Signatory).

    b. The Grantee will be given a sufficient number of days to review the Grant Agreement. CalOptima Health will work with the Grantee to finalize the Grant Agreement.

F. Post-Award: Payment of Grant Fund Disbursements

1. Upon receipt of the fully executed Grant Agreement, CalOptima Health will process payments according to the established payment schedule.

2. CalOptima Health will review Progress Reports, invoices, receipts, and other documentation to determine whether adequate progress toward program objectives and fund expenditure has been achieved and that Grant fund expenditures are appropriate before releasing subsequent Grant fund disbursements.

3. Upon completion of the Grant program and closeout review, CalOptima Health will obtain any funds that are found to not have been utilized in accordance with the Grant Agreement.

G. Post-Award: Grant Performance Monitoring and Reporting Requirements

1. CalOptima Health will review Progress Reports and request meetings as needed to monitor compliance and progress towards achieving the objectives in the Grant Agreement.

2. The Grantee will submit Progress Reports based on schedule and frequency indicated in the Grant Agreement to CalOptima Health, detailing Grantee activities, along with any required supporting materials through the submission method agreed upon by Grantee and CalOptima Health Sponsoring Department.

3. The Progress Report will include a breakdown of funding utilization by category as required by the Grant Agreement.

4. CalOptima Health may conduct site visits to a Grantee's business premises and/or site(s) of Grant- funded service delivery during the Grant Agreement term for the following actions including, but not limited to:

    a. Meet the Grantee's senior leadership, as well as the Grantee's staff or volunteers with primary responsibility for conducting the funded activities;

For 20250807 BOD Review Only

b. Engage in dialogue with the Grantee about progress toward project milestones and objectives, successes, implementation challenges, and early lessons learned;

c. Learn of any anticipated requests for scope or budget changes, or no-cost extension; and

d. See program services/activities first-hand, if applicable and feasible.

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6. The Grantee will submit an electronic copy of their annual independent audit each year within thirty (30) days of its completion.

H. Post Award: Grant Agreement Changes:

1. All Grant Agreement changes must be finalized prior to the expiration of the Grant Agreement.

2. Requests for changes must be received in writing.

3. CalOptima Health will determine whether a requested change is considered a limited change or a material change.

a. Limited Change

i. A limited change to a Grant Agreement does not affect the scope of work or increase the Grant funding amount requested and is within the grant program parameters approved by the Board of Directors.

ii. A limited change may include but not be limited to:

a) A no-cost extension within the same fiscal year;

b) Expenditure shifts between line items in the originally approved budget but within the approved amount; and

c) Minor resource shifts or changes from the original targeted project plan.

iii. If a requested change is determined to be limited in nature, the change can be approved by the Sponsoring Department.

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a) Significant changes to the targeted activities or outcome(s) funded by the grant award;

b) Any impact to the program schedule or duration causing delay to program implementation that impacts Board-approved funding, i.e. the grant period will extend into a new fiscal year; and

For 20250807 BOD Review Only

Back to Agenda Back to Item

c) A significant reduction in the activities indicated in the Grant Agreement.

ii. If a change is determined to be material in nature, the change must be approved by the Sponsoring Department and the Board of Directors through the COBAR process.

4. If the request is approved, CalOptima Health staff will generate a Grant Agreement amendment document. The document will be sent electronically to the Grantee's point of contact. The document must be signed by the Official Signatory. All signatures on the Grant Agreement amendment must be obtained prior to expiration of the Grant Agreement. Notice of the fully executed Grant Agreement amendment will be sent electronically.

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1. At the end of the Grant term, each Grantee will submit a Final Report as outlined in the Grant Agreement, summarizing the activities completed by the Grantee over the course of the entire Grant term, and analyzing its performance against the Grant objectives. The Final Report will include a breakdown by category of the funds used and a reconciliation to indicate all funds were used according to their intended purposes.

2. CalOptima Health will conduct a Grant close-out review that will:

a. Validate that the scope of work and performance objectives of the Grant Agreement were completed;

b. Verify final spending reports and reconcile with Finance;

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d. Review Final Report for completeness;

e. Retain records for documents, reports, financial documentation, and any other related program artifacts in CalOptima Health SharePoint site; and

f. Conduct a lessons learned review, if applicable.

3. CalOptima Health shall recoup any unspent grant funds after completion of the project as agreed to in the Grant Agreement.

J. Post Award: Grant Audit

1. CalOptima Health may conduct audits of the Grantee's use of Grant funds and/or of the related CalOptima Health operational areas and financial data during the course of the Grant and/or at the conclusion of the Grant.

a. The audits will be conducted to confirm reported expenditures, performance measures, compliance with key Grant requirements, and other relevant factors as applicable to the specific Grant.

For 20250807 BOD Review Only

Back to Agenda Back to Item

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
B. CalOptima Health Policy GA.5002: Purchasing

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
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For 20250807 BOD Review Only

IX. GLOSSARY

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For 20250807 BOD Review Only

Back to Agenda Back to Item

CalOptima Health

Updates in Grant Oversight and Management

Board of Directors Meeting

August 7, 2025

Danielle Cameron, Senior Director, Grant Programs, Medi-Cal and CalAIM

Our Mission

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

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Governance and Oversight

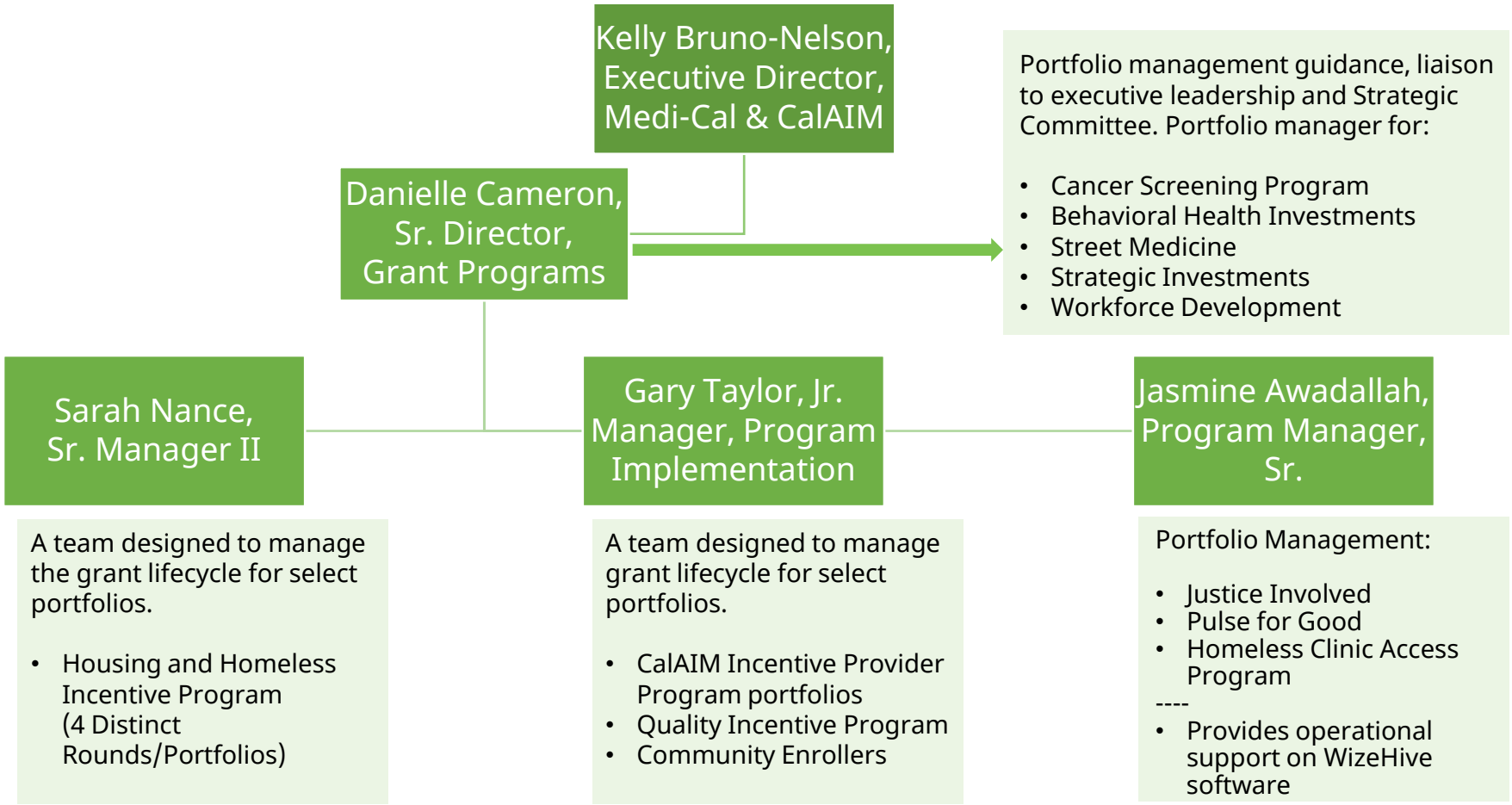
- Established Strategic Community Investment Committee
  - Representation from Chief-level and Executive Director-level from key departments.
  - Monthly presentations on new funding opportunities and selection processes; progress report-outs on existing grant portfolios; and overview of synergies, challenges and successes.
  - Previews potential funding opportunities and provides recommendations of what should be taken through to the COBAR process for board approval.

Grant Management Department

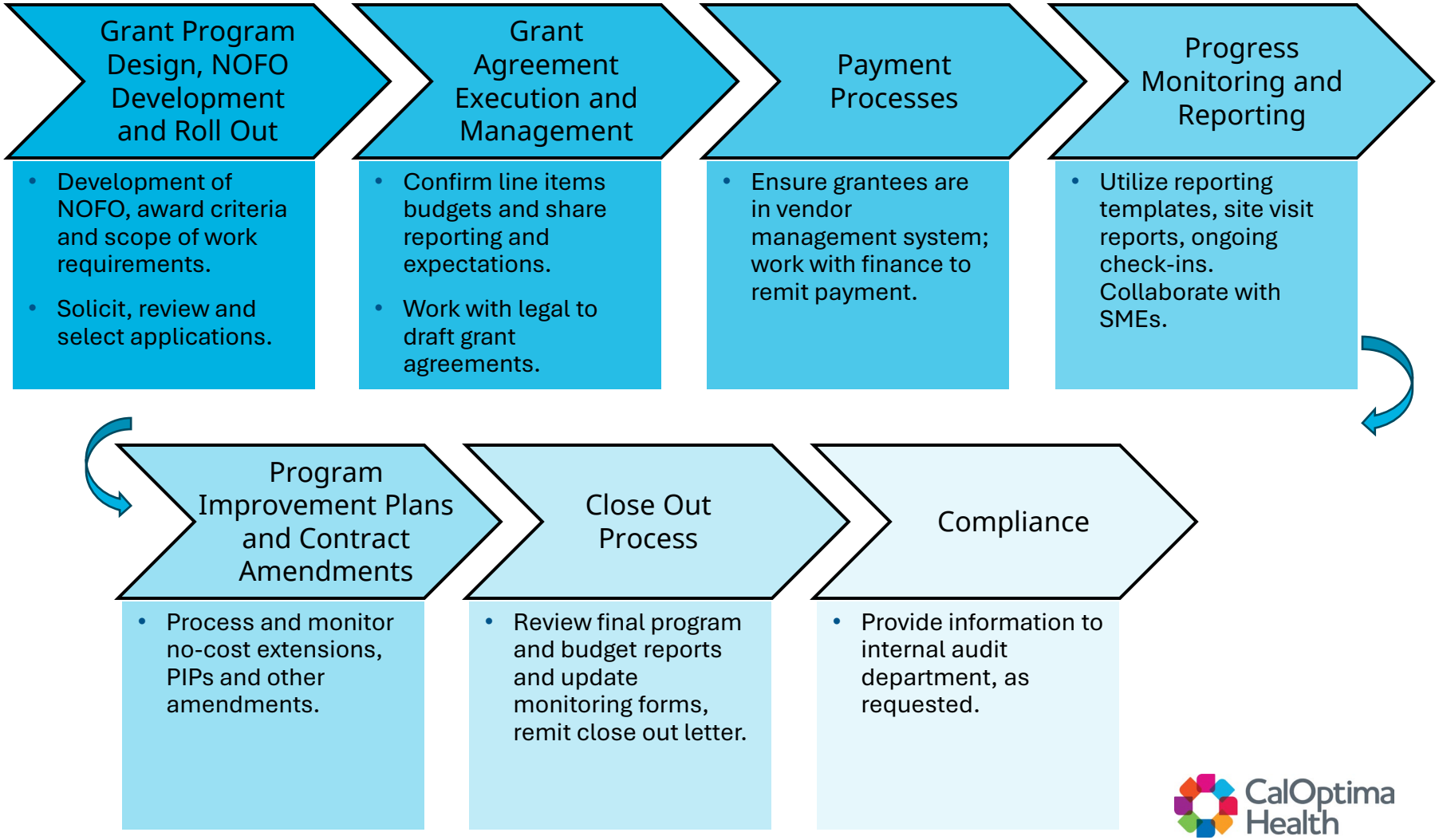
- **Purpose:** provide consistent grant lifecycle support across all departments (details to follow).
- **Experience:** Executive Director and Senior Director collectively over 45+ years experience across a variety of philanthropic organizations. Managers bring experience in process execution, CBO management, and program implementation.
- **Structure:** Executive Director provides leadership to Senior Director who supports three managers. Collectively they oversee all grant portfolios.

CalOptima Health

Grant Management Department



Grant Lifecycle Management



CalOptima Health

Key Forms and Templates

CalOptima Health

Housing and Homelessness Incentive Program (HHIP) Round 3: Notice of Funding Opportunity (NOFO)

CalOptima Health solicits equity, systems change, and transitional housing capital funding requests for people experiencing homelessness.

Application Deadline — February 22, 2024 (5 p.m. PST)

Background

CalOptima Health's mission is to serve member health with excellence and dignity, respecting the value and needs of each person. With a strategic goal of decreasing health inequities, CalOptima Health is engaging in programs and expanding partnerships to better serve members who are at greater risk for poor health outcomes, especially those experiencing homelessness.

Application Timeline

Action	Date
Application Released/Portal Opens	1/17/2024
Round 3 NOFO – Bidder's Conference * *Q&A posted on the Funding Opportunity webpage by 2/5/2024*	1/31/2024 at 11 a.m. PST
Application Deadline	**2/22/2024 at 5 p.m. PST**
Internal Review	2/23 – 3/8/2024
CalOptima Health Board of Director's Meeting	4/4/2024
Announcement of Approved Grants	4/5/2024
Grants Start Date	5/1/2024

Documents and Portal Access

All documents related to this NOFO and application portal access are available at this site:
https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/FundingOpportunities

Bidder's Conferences

Join our Bidder's Conference for this funding opportunity by registering through the link below:

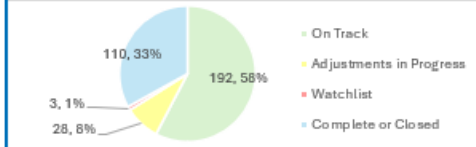
Bidder's Conference
Date and Time: Wednesday, January 31, 2024, 11 a.m. PST
Link: https://us06web.zoom.us/webinar/register/WN_vcAqy2XoQJyATU_yCiSrPg

Questions about the funding opportunity or application? Contact the CalAIM Program Development team at CalAIM@caloptima.org.

CalOptima Health Grants Monitoring Report

Prepared July 1, 2025

Current Pulse Check Across All CalAIM Grants



Total Grants = 333

Grant Assessment Key

Grant program is on track for timeline, objectives and budget. All reports and progress meet expectations.

Grant program is delayed or off track and adjustments are in progress. Staff is actively working with grantee to address program or spending performance. The program is not at risk, but needs additional attention to ensure it stays aligned.

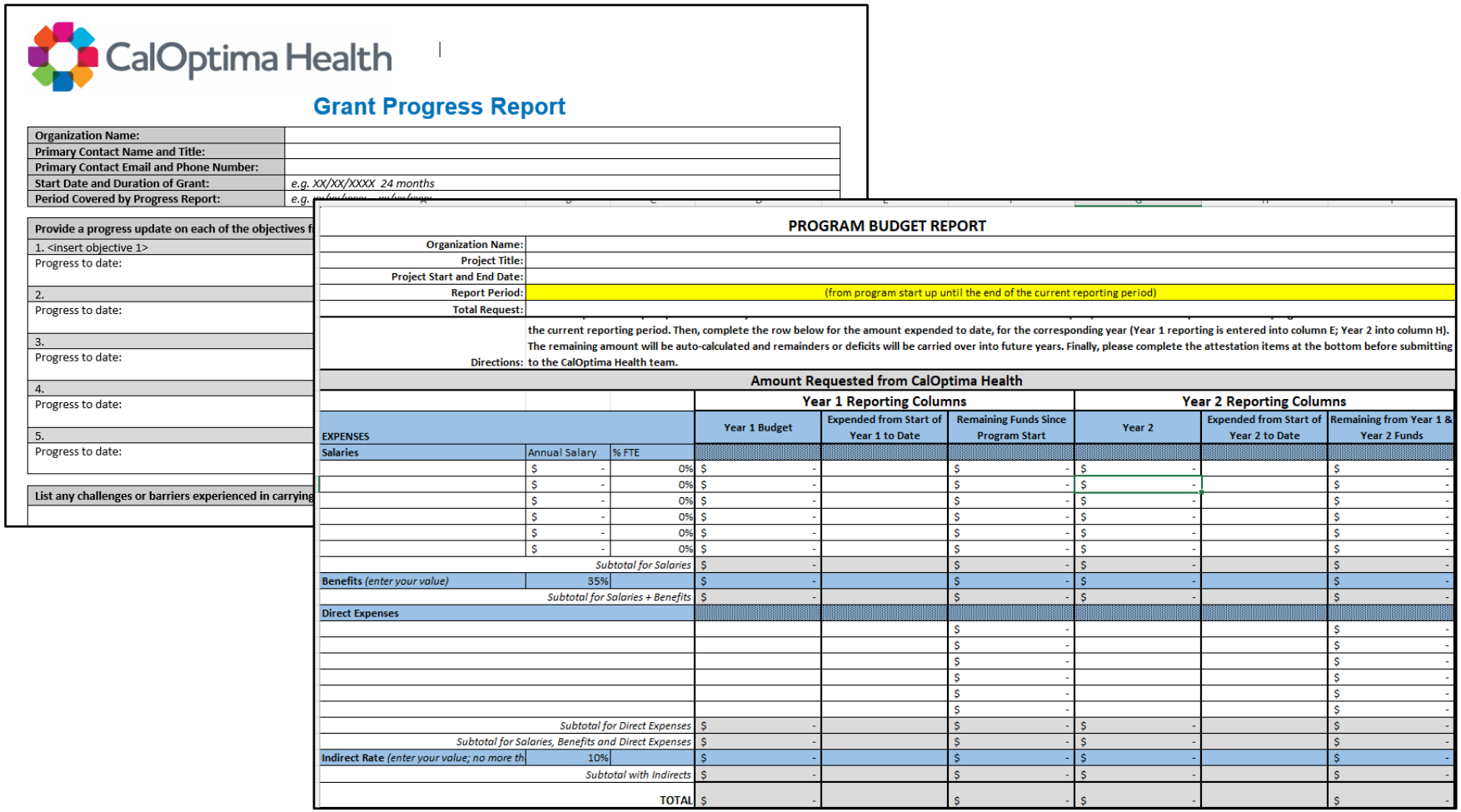
Grant program is on a watch list and not progressing enough toward outcomes or spending. Grantees are completing Performance Improvement Plans. Staff are actively involved to ensure program can be returned to "on track." Executive team or legal counsel advise on any potential agreement amendments, recoupment of funds, or other actions needed.

Grant program completed or terminated upon mutual agreement.

*Pg.	Portfolios Under Active Management	Portfolio Value	# of Grants	Grant Status Breakdown Across Each Portfolio
2	Dyadic Care	$ 1,871,250	1	1
3	Street Medicine	$ 19,257,658	6	4 1 1
4	HHIP- Round 1	$ 36,631,423	35	8 1 1 25
5	HHIP- Round 2	$ 52,300,000	15	10 5
6	HHIP- Round 3	$ 25,780,000	14	14
7	HHIP – Round 4	$ 2,700,000	6	6
8	Pulse for Good	$ 660,000	22	20 2
9	Homeless Clinic Access Program	$ 1,112,500	8	6 2
10	Community Health Worker	$ 2,100,000	21	19 2
11	Community Enrollers	$ 4,073,325	12	12
12	Community Supports Capacity 2022	$ 1,700,000	17	1 16
13	Community Supports Capacity 2023	$ 2,100,000	21	19 3
14	Initial Launch of CalAIM Capacity	$ 5,153,938	8	2 1 5
16	ECM Academy Cohort 2	$ 1,800,000	18	3 15
16	ECM Academy Cohort 3	$ 1,200,000	12	11 1
17	Justice Involved Learning Network	$ 1,000,000	5	5
18	Cancer Screening Program	$ 16,417,044	15	11 4
19	Quality Incentive Grant Program	$ 4,943,069	37	37
20	OC HCA Be Well Hubs	$ 11,400,000	1	1
21	Workforce Development R1	$ 24,596,300	7	7
22	Workforce Development R2	$ 5,140,772	6	6
23	Strategic Investments (multi-dept)	$ 83,700,000	6	3 2 1
24	OC OCC – Project Homekey *(closed)*	$ 2,500,000	1	1
25	Nonprofit Healthcare Academy *(closed)*	$ 190,000	38	38
	TOTALS	$308,427,279	333	

*Additional portfolio detail can be found at the reference page.

Key Forms and Templates



CalOptima Health

Grant Progress Report

Organization Name:	
Primary Contact Name and Title:	
Primary Contact Email and Phone Number:	
Start Date and Duration of Grant:	e.g. XX/XX/XXXX 24 months
Period Covered by Progress Report:	e.g.

Provide a progress update on each of the objectives f
1. <insert objective 1>
Progress to date:
2.
Progress to date:
3.
Progress to date:
4.
Progress to date:
5.
Progress to date:

List any challenges or barriers experienced in carrying

PROGRAM BUDGET REPORT

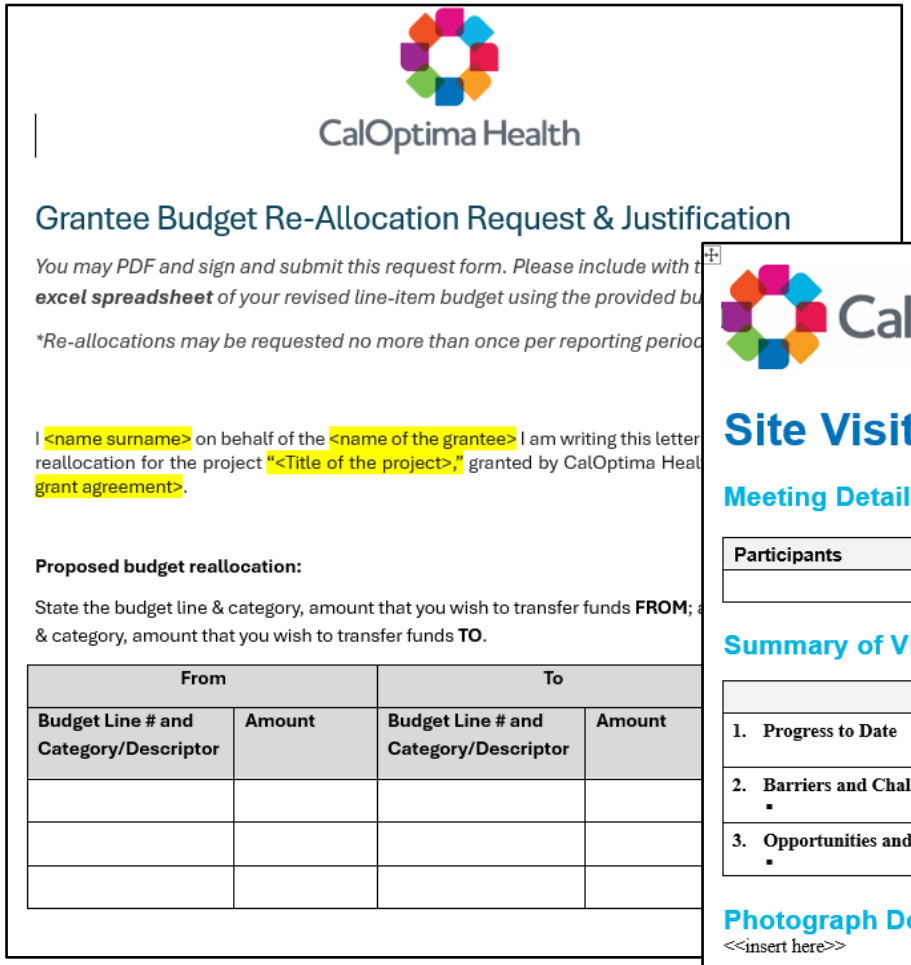
Organization Name:	
Project Title:	
Project Start and End Date:	
Report Period:	(from program start up until the end of the current reporting period)
Total Request:	
Directions:	the current reporting period. Then, complete the row below for the amount expended to date, for the corresponding year (Year 1 reporting is entered into column E; Year 2 into column H). The remaining amount will be auto-calculated and remainders or deficits will be carried over into future years. Finally, please complete the attestation items at the bottom before submitting to the CalOptima Health team.

Amount Requested from CalOptima Health

			Year 1 Reporting Columns			Year 2 Reporting Columns		
EXPENSES			Year 1 Budget	Expended from Start of Year 1 to Date	Remaining Funds Since Program Start	Year 2	Expended from Start of Year 2 to Date	Remaining from Year 1 & Year 2 Funds
Salaries	Annual Salary	% FTE						
	$ -	0%	$ -		$ -	$ -		$ -
	$ -	0%	$ -		$ -	$ -		$ -
	$ -	0%	$ -		$ -	$ -		$ -
	$ -	0%	$ -		$ -	$ -		$ -
	$ -	0%	$ -		$ -	$ -		$ -
	$ -	0%	$ -		$ -	$ -		$ -
		Subtotal for Salaries	$ -		$ -	$ -		$ -
Benefits *(enter your value)*	35%		$ -		$ -	$ -		$ -
		Subtotal for Salaries + Benefits	$ -		$ -	$ -		$ -
Direct Expenses								
					$ -			$ -
					$ -			$ -
					$ -			$ -
					$ -			$ -
					$ -			$ -
					$ -			$ -
		Subtotal for Direct Expenses	$ -		$ -	$ -		$ -
		Subtotal for Salaries, Benefits and Direct Expenses	$ -		$ -	$ -		$ -
Indirect Rate *(enter your value; no more th*	10%		$ -		$ -	$ -		$ -
		Subtotal with Indirects	$ -		$ -	$ -		$ -
		TOTAL	$ -		$ -	$ -		$ -

CalOptima Health

Key Forms and Templates



CalOptima Health

Grantee Budget Re-Allocation Request & Justification

You may PDF and sign and submit this request form. Please include with t

***excel spreadsheet** of your revised line-item budget using the provided bu*

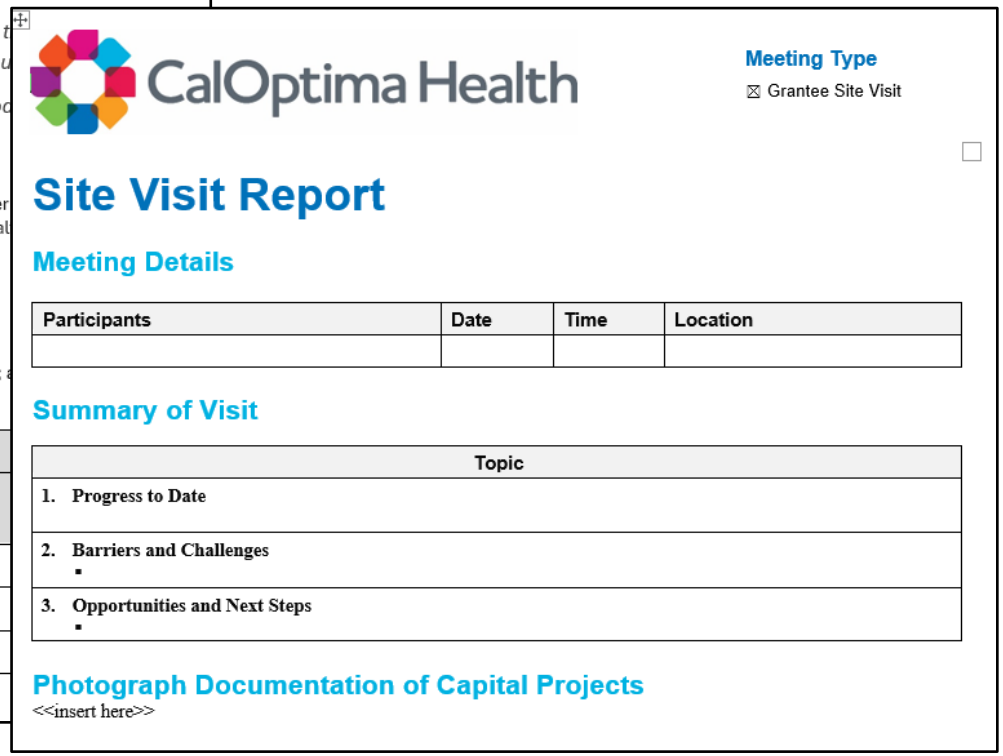
**Re-allocations may be requested no more than once per reporting period*

I <name surname> on behalf of the <name of the grantee> I am writing this letter
reallocation for the project "<Title of the project>," granted by CalOptima Heal
grant agreement>.

Proposed budget reallocation:

State the budget line & category, amount that you wish to transfer funds **FROM**;
& category, amount that you wish to transfer funds **TO**.

From		To	
Budget Line # and Category/Descriptor	**Amount**	**Budget Line # and Category/Descriptor**	**Amount**



CalOptima Health

Meeting Type

☒ Grantee Site Visit

☐

Site Visit Report

Meeting Details

Participants	Date	Time	Location

Summary of Visit

Topic
1. **Progress to Date**
2. **Barriers and Challenges** ▪
3. **Opportunities and Next Steps** ▪

Photograph Documentation of Capital Projects

<<insert here>>

CalOptima Health

Next Steps

- Over the past few months, the Grants Management Department has been acquiring portfolios from across the organization. By the close of this fiscal year all grants will:
  - Have consistent award agreement language, scope of work and measurable outcomes;
  - Have been incorporated into the standardized grant monitoring process; and
  - Be using all templated forms and documentation strategies.

CalOptima Health

Continued to the September 4, 2025 Board Meeting

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 7, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item
15. Approve New CalOptima Health PACE Policy PA.9003: PACE Letters of Support

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Javier Sanchez, Executive Director, Medicare Programs, (714) 986-6115

Recommended Actions
Authorize the Chief Executive Officer to implement a policy and procedure to consider requests for letters of support from organizations seeking to offer Program of All-Inclusive Care for the Elderly services in Orange County independently from CalOptima Health.

Background
On October 27, 2017, and on August 17, 2018, the Department of Health Care Services (DHCS) issued a Program of All-Inclusive Care for the Elderly (PACE) policy letters regarding the PACE application process, including guidance on the operation of an independent PACE facility in County Organized Health System (COHS) counties like Orange County. Historically, the only entity that could operate a PACE program in a COHS county was the designated Medi-Cal managed care plan. Welfare & Institutions Code Section 14087.5 et seq. provides that a managed care plan that elects to organize as a COHS holds the exclusive right to contract for Medi-Cal services, including PACE, in the respective county. DHCS policy letters describe a process by which an organization interested in becoming an independent PACE Organization (PO) in a COHS county may, with the formal support of the local COHS plan, be considered by the COHS to operate in that county(s). Specifically, DHCS will only consider an application from an independent PO in Orange County if its application to DHCS includes a letter of support from CalOptima Health. In the letter, CalOptima Health as a COHS plan, must take the significant step of requesting that DHCS submit a formal request to the Centers for Medicare & Medicaid Services (CMS) requesting an amendment to California's existing Section 1115 Medicaid Waiver to make an exception to the existing law that governs COHS plans as part of the independent PO application process. COHS plans, including CalOptima Health, are under no obligation to provide such letters of support.

On September 6, 2018, CalOptima Health's Board of Directors (Board) authorized the Chief Executive Officer (CEO) to establish a process for considering and issuing letters of support to entities seeking to establish a PO independent of CalOptima Health. Since 2018, CalOptima Health has provided letters of support to Alta Med PACE and Innovative Integrated Health PACE, which successfully completed the DHCS and CMS application processes and are currently providing PACE services to many Orange County residents in selected zip codes.

Back to Agenda

Continued to the September 4, 2025 Board Meeting

Discussion
The PACE model has significantly expanded across California. CalOptima Health staff frequently receive inquiries from entities seeking to establish a PO in Orange County. To address these requests, CalOptima Health staff developed Policy PA.9003, PACE Letters of Support, to expand and formalize the process for considering such requests. This new policy will expand on the process previously approved by the Board in 2018, by updating the process for properly and objectively screening applicants according to current PACE industry dynamics, DHCS policy and CMS regulatory requirements.

Fiscal Impact
The recommended action is operational in nature and has no direct fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2025-26 Operating Budget.

Rationale for Recommendation
Approval of PACE Policy PA.9003 will establish a formal process for CalOptima Health staff to process requests and the Board to consider approving letters of support for entities seeking to establish a new PO or to expand the service area of POs currently operating in Orange County.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. DHCS Policy Letter 23-01
2. Draft Policy PA.9003: PACE Letters of Support
3. Prior Board Action dated September 6, 2018, "Consider Approval of Process for Considering Requests for Letters of Support from Organizations Seeking to Offer Program of All-Inclusive Care for the Elderly (PACE) Services in Orange County Independent of CalOptima"
4. Letter of Support

Board Action

Board Meeting Dates	Action	Term	Not to Exceed Amount
April 4, 2019	Authorize Letters of Support for AltaMed Health Services and Innovative Integrated Health, Inc.	N/A	

/s/ Michael Hunn *07/31/2025*
Authorized Signature **Date**

Back to Agenda

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

Date: April 14, 2023

Policy Letter 23-01

Supersedes PACE Policy Letter 19-01

To: Program of All-Inclusive Care for the Elderly Organizations

Subject: Program of All-Inclusive Care for the Elderly Application Process

Purpose

The purpose of this Policy Letter (PL) is to inform Program of All-Inclusive Care for the Elderly (PACE) Organizations (POs) and potential applicant organizations of the Department of Health Care Services' (DHCS) application review process and timeline for new PO applications and PO Expansion applications. This PACE Policy Letter, like all PACE Policy Letters, has the force and effect of state regulation as set forth in Welfare &Institutions Code section 14592(k). DHCS uses the criteria defined in this letter to make a determination to approve, deny or defer an application.

Background

In 2016, the California Legislature passed the PACE Modernization Act Trailer Bill (Sections 31-36 of SB 833, Chapter 30, Statutes of 2016) including updates to the payment and regulatory structure of PACE. The updated California PACE statutes, in part, removed the cap on the number of PO's that could operate in the state, and allowed for-profit entities to become POs.

Centers for Medicare & Medicaid Services (CMS)

The Centers for Medicare & Medicaid Services (CMS) releases annual updates to its PACE Application Guidance to address its electronic PACE application submission timelines, requirements, and review process. Applicants should review this guidance and be aware of CMS requirements for accessing the Health Plan Management System (HPMS). The downloadable PDF of the application and additional information can be found on CMS' website. [1]

State Application Review Process

All new and expansion PACE applications must go through an initial review process by DHCS in order to move forward with submission to CMS via HPMS. The initial submission components provide DHCS with key organizational background and

[1] https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html

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financial viability documentation. This information is necessary for DHCS to complete/sign the State Assurance pages and authorize the submission of the full application to DHCS and CMS via HPMS.

Upon submission of the full application to CMS, DHCS will align its review of the remaining application with the CMS clock cycle, dependent upon the type of application, to create a concurrent review process. Expansion only applications will be on two 45/90 day clock cycles. New PACE center applications will be on two 90 day clock cycles. The initial CMS 45/90-day clock review begins upon receipt of the completed full application in HPMS, which must include the signed State Assurance pages.

DHCS will review the application according to state and federal laws and regulations, contractual requirements, and implementing Policy Letters. Prior to entering into a contract for the provision of Medi-Cal managed health care services, DHCS may consider any factor it determines to be necessary for consideration (Welfare & Institutions Code §§ 14095 and 14592(b)). This includes considering any information relevant to the issue of whether the application could result in unnecessary duplication of services or impair the financial or service viability of an existing program (42 USCA § 1395eee(e)(2)(B)).

DHCS will verify that the applicant is in good standing which includes but is not limited to:

- The applicant and any parties that make up the organization may not be on a Medicaid/Medicare exclusion list.
- Any Medicaid/Medicare line of business operated by the applicant cannot be under sanctions or facing civil monetary penalties from any local, state, or federal government entity.

Applications will not be accepted from existing POs or application entities that currently have some form of Medicaid/Medicare sanction or civil monetary penalty on the entity or parent organization.

If an application entity or parent entity is undergoing a state or federal audit, or is in the process of developing or implementing a Corrective Action Plan, DHCS has the option to delay a final decision on issuance of the State Assurances for any application packet until the conclusion of the audit or Corrective Action Plan of the applying organization or the parent entity if DHCS has significant concerns or findings during those audits. If an audit results in significant findings supporting sanctions or civil monetary penalties, the state will require the PO to withdraw the application and will not allow re-submission until the findings and/or sanctions have been resolved through a corrective action plan as has been identified in the audit process.

Initial State Review

All new and expansion applications received by DHCS will follow the below initial state review timeframes for application submission:

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Action	Due Date	Documents for *PO* Submission	Reviewer	Review Timeframe
Applicant Notification of Intent to DHCS	30 days prior to Initial Application Submission to DHCS	• Letter of Intent • Letter for Support from COHS (if applicable) • Address of new PACE center Estimated operational date (subject to DHCS approval)	DHCS	30 calendar days
Initial Application Submission to DHCS	90 days prior to CMS application submission deadline	• Market Feasibility Study • Letters of Support • Application sections (see Attachment III) • Address of PACE center	DHCS	90 Calendar Days
Full Application Submission in HPMS	Align with CMS PACE Application Submission Deadline	• Remaining application sections • State Assurance (Attestation) Page	DHCS & CMS	Align with CMS 45/90 day review clock

If DHCS defers the decision on an application for two consecutive quarters due to the applicant not meeting the requirements of this Policy Letter and all applicable state and federal requirements, DHCS will deny the applicant. If an applicant has been denied DHCS will not accept a new or expansion application submission for a period of two quarters.

Concurrent Federal and State Review

The CMS review process of the PACE Application will include a series of attestations and uploads based on the type of application received (Initial Application or Service Area Expansion SAE)). Please see Attachment I (PACE Application Required Attestations and Uploads). DHCS will sign the attestation pages and release to applicant along with the state appendices, M, N, P, Q, R, and S. The applicant will then submit the signed attestation and state appendices to CMS by the quarterly submission deadlines.

During the initial CMS 45/90-day clock review of the full application, CMS and/or DHCS may issue a Request for Additional Information (RAI) to the applicant. In the event a RAI is issued, the application is taken off the review clock while the applicant responds to the RAI. DHCS will align its remaining review and RAI (if necessary) with CMS timelines and ensure that any necessary changes are communicated to CMS.

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It is also during this period that DHCS conducts the State Readiness Review (SRR) onsite survey of the applicant PACE Center, as required. All initial applications, and any SAE application that includes the addition of a new PACE center, require an SRR of the new center. All deficiencies identified during the DHCS SRR onsite survey of the applicant PACE Center must be addressed through a corrective action plan submitted to and accepted by DHCS. The applicant must revise the corrective action plan per DHCS request, until DHCS approves it to move forward. The application will not be moved forward until the applicant successfully completes the DHCS approved corrective action plan.

Once CMS and/or DHCS have accepted the applicant's RAI response, and the SRR onsite survey has been satisfactorily completed by DHCS and accepted by CMS, CMS will reinitiate the final 45/90-day clock review cycle. Conclusion of this cycle results in CMS notification to the applicant of final approval or denial. The application will be denied if any of the criteria set forth in this letter are not met or addressed through the RAI process.

PACE Growth and Expansion

All PACE growth and expansion falls into one of the below categories:

1. New PACE Organization – A new entity applying to establish a PO
    - An entity must identify specific zip codes to be served in one or more counties.
    - An entity must identify zip codes that overlap with any existing operational POs and potential POs with pending applications. Information on obtaining information regarding existing and potential POs is set forth below.
    - An entity must be able to serve all requested zip codes from the PACE Center (subject to the 60-minute one-way drive time to and from the participants' homes to the adult day health center (ADHC)).
    - Rate development is required for each county requested, refer to "Program Start Date" section below.
2. Existing PO Expansion (Existing County) – PO's adding additional zip codes within the existing county service area, opening a new PACE Center within the existing county service area, or both
    - An entity must be able to serve all requested zip codes from the PACE Center(s) subject to the 60-minute one-way drive time to and from the participants' homes to the ADHC requirement, as specified below.
    - An entity must identify zip codes that overlap with any existing operational POs and potential POs with pending applications. Information on obtaining information regarding existing and potential POs is set forth below.
    - POs can add zip codes and use Alternative Care Settings (ACS) as an interim step before building new PACE Center.

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  - For ACS requests, refer to CMS Guidance Memorandum "Alternative Care Settings in the PACE Program".
- DHCS and its actuaries must analyze the requested expansion for potential rate impact. If a rate impact is identified (requiring new rate development), the request will be treated in accordance with the program start dates outlined below.
- Zip code only expansions are subject to a shorter CMS review period.

3. Existing PO Expansion (New County) – PO adding zip codes in a new county of operation

- Usually requires a new PACE Center unless the zip codes requested fall within the required radius to be served by the existing PACE Center and interdisciplinary team (IDT).
- An entity must identify zip codes that overlap with any existing operational POs and potential POs with pending applications. Refer to the "PACE Expansions Proposals" document posted on a monthly basis on the DHCS PACE website.[2]
- Rate development is required for each new county requested and are subject to the January and July program start dates detailed below.

Program Start Date

To align with DHCS budget and rate development processes, all new and existing PO expansion applications requiring new rate development may only be able to begin operations on either January 1 or, July 1, of a given year in accordance with the timeline below.

Applications submitted to CMS in the quarterly windows from January through June of a given calendar year may begin operations no sooner than July 1 of the subsequent calendar year, pending final DHCS and CMS approval of the new PACE Organization or Existing PO Expansion application.

Applications submitted to CMS in the quarterly windows from July through December of a given calendar year may begin operations no sooner than January 1 of the calendar year that follows the subsequent calendar year (i.e., a December 31, 2022 submission would be eligible for a January 1, 2024 start date), pending final DHCS and CMS approval of the new PO or SAE application.

Prospective POs and expansion applicants requiring new rate development should consider the available start dates when preparing to submit an application. Any delays in the application submission or review process may result in the program start date getting pushed back to the next available program start date of either January 1 or July 1.

[2] Program of All-Inclusive Care for the Elderly ("PACE Expansions Proposals" Link)

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Applicants should also account for the time frame requirements of other public licensing entities (e.g., California Department of Public Health) when considering the overall application timeline process.

All new POs, and existing POs in new Counties, must initiate marketing activities immediately upon the approval of the three-way program agreement and must begin processing enrollments immediately following the go-live date.

Letter of Intent Submission Components

Thirty days prior to submitting an initial application to DHCS, all applicants must submit to DHCS a Letter of Intent (LOI) indicating their plans to submit a PACE application. The LOI must identify and/or include the following:

- The applicant;
- The proposed service area, including a listing of proposed zip codes and a service area map with:
  - The location of the PACE center clearly marked;
  - A scale of the complete geographic service area that includes county, zip code, street boundaries, census tract or block or tribal jurisdiction, main traffic arteries, physical barriers such as mountains and rivers, hospital providers, ambulatory and institutional services sites;
  - The drive time from the farthest points on the geographic boundaries to the PACE Center, Including allowances for traffic as well as assistance time and multiple participants. The PO needs to be able to effectively serve the entire proposed service area in the first year of operation; and
  - The drive time to the nearest ambulatory and institutional service sites.
- If the geographic service area includes an area covered by another PACE organization, provide a list of overlapping zip codes as well as identifying all overlap areas in the service area map;
- Letter of support from COHS, as described below;
- The address for the applicant's PACE center,[3] and
- The anticipated operational date of the center (subject to DHCS approval) based on DHCS program start date guidelines above.

If an applicant wishes to withdraw their LOI an email must be sent to the DHCS team which confirmed receipt of the LOI and is reviewing the application. The withdrawal email must include details behind the circumstances that led to the withdrawal and whether they plan on submitting a new LOI in a future quarter.

All applicants proposing to serve an area with an existing or pending PACE plan must identify the overlapping zip codes in their LOI. If an applicant has any questions about whether there is an existing or pending PO operating in its proposed service area it can

[3] *NOTE: Once the initial application has been submitted to CMS, the PACE Center address cannot be changed. If the PACE Center address changes, the applicant will need to withdraw their initial application with CMS and DHCS and the application process will start over, requiring the submission of a new LOI.*

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refer to the DHCS PACE website[4] for a listing of all zip codes by county that PO's currently operate in. Pending applications for new or expansion PO's are also posted to the DHCS website.[5]

CMS application submission deadlines can be found under the application training guide on CMS' website.[6]

The LOI to DHCS must be submitted at least 120 days prior to the proposed CMS submission date, and the initial application must be submitted at least 90 days prior to the proposed CMS submission date. Applications submitted to DHCS after these dates will not be accepted and will need to be resubmitted for a subsequent CMS quarterly submission date cycle.

Initial Application Submission Components

Letters of Support

All PACE applicants must submit letters of support from local entities or individuals in the area that the applicant proposes to serve. The purpose of these letters is to demonstrate that the applicant is connecting with local entities who will work closely with the incoming PO and provide community support. These may include but are not limited to: political representatives, County Board of Supervisors, County Health and Human Services (HHS) Director, local hospitals, Medi-Cal managed care health plans (MCPs), Independent Physician Associations (IPAs), Commission on Aging, Area Agencies on Aging (AAA), and Community Based Organizations (CBOs). Letters of support should be attached to the initial application.

At a minimum, applicants must submit:

- three (3) letters of support from local government agencies or political representatives,
- three (3) letters of support from local health care providers operating in the proposed service area, and
- three (3) letters of support from CBOs (colleges, churches, social service groups, etc).

DHCS reviews letters of support and may reject a letter based on the following criteria:

- The entity writing the letter of support does not operate within or represent the requested service area.
- The entity writing the letter of support has a financial interest in or has been engaged by the applicant for consulting purposes.

[4] http://www.dhcs.ca.gov/individuals/Pages/PACEPlans.aspx
[5] https://www.dhcs.ca.gov/services/ltc/Pages/programofall-inclusivecarefortheelderly.aspx
[6] https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html

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For PACE applicants wishing to serve in COHS and Single Plan Model Counties, refer to the "POs in County Organized Health System and Single Plan County Model Counties" section later in this letter.

Market Feasibility Study

All PACE applicants, including SAEs, must submit to DHCS a market feasibility study of the area that they propose to serve. The feasibility study must include the following:

- Estimate of the number of PACE-eligible individuals
- Description of the methodology/assumptions used to determine potential membership
- Identify all competitive factors impacting the market, such as:
  - Existing PO's
  - Medi-Cal MCPs
  - Demonstration County MCPs (Cal MediConnect and Managed Long-Term Services and Supports (LTSS))
  - Dual Special Needs Plans (D-SNPs)
  - Medi-Cal Waiver Programs
  - In-Home Supportive Services (IHSS)
- Identify projected market capture/saturation rates
- Demonstrate that there is an unmet need for PACE in the proposed service area
  - Please note that when multiple applications are received for the same county/zip code service area the order of submission and number of pre-existing plans may have an impact on the decision to approve/deny an application.

State Application Narrative

The following PACE application sections must be submitted to DHCS for initial review (see Attachment III): Please refer to DHCS website "PACE Orientation Package & Approved Templates" for resource and templates.

New PACE Application	**Service Area Expansion (Existing and New County)**
• 3.1 – Service Area • 3.2 – Legal Entity and Organization Structure • 3.3 – Governing Body • 3.4 – Fiscal Soundness • 3.5 – Marketing • 3.13 – Contracted Services • 3.23 – Transportation Services	• 3.1 – Service Area • 3.4 – Fiscal Soundness • 3.5 – Marketing • 3.13 – Contracted Services • 3.23 – Transportation Services

In addition to the attestations and documents required in the PACE application, the applicant must provide DHCS a detailed narrative covering each of these sections to

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demonstrate to DHCS the organizational background and financial standing of the applicant. Applicants should refer to the Attachments in this document as well as the documents on the DHCS PACE website under PACE Orientation Package & Approved Templates.[7]

Financial Documentation

The applicant must demonstrate evidence of sufficient capital and/or capital funding to finance the PACE entity or expansion through the projected breakeven point, while maintaining sufficient reserves as required by 42 CFR § 460.80 - Fiscal soundness and the application process. In demonstrating this, DHCS also requires that the documentation must show that the applicant's assets are greater than the unsubordinated liabilities, including when the applicant is applying for funding. Applicants must clearly document all funding being utilized for this application, including documentation of the source of funding and documentation of any agreements related to the funding. The proforma documents submitted by the applicant must contain reasonable assumptions for projected PACE cost and revenue from start up to the breakeven point.

Additional Considerations and Limitations

60 Minute Drive Time Analysis

The applicant is responsible for developing the initial 60-minute drive time analysis for each zip code identified in the initial application. Applicants must use the farthest points in the geographic boundaries to the PACE center. Applicants must take into consideration and incorporate time measures when multiple participants are being transported at the same time, while ensuring safety and all participant needs are being met. Applicants must also consider high traffic times in highly populated urban areas. The applicant must use commute hours of 6:00am to 8:00am and 2:00pm to 4:00pm. DHCS will review the initial analysis and conduct their own review. DHCS will identify a landmark at random in the farthest point of the zip code and calculate the drive to and from that landmark. DHCS calculates the drive using multiple traffic patterns throughout the day. If DHCS determines a zip code does not meet the drive time requirements, while taking into consideration all the factors listed above, the applicant will be required to remove the zip code from their application. DHCS will be unable to move forward with an application in which an applicant has refused to remove the request zip codes.

Multiple Initial Applications at Once

DHCS will not permit sponsoring or parent organizations applying to become a PACE Organization to submit a new initial application requiring a new "H" number until the current PACE Organizations under their scope have demonstrated their success in operating a PACE program and have passed their first trial period audit.

[7] https://www.dhcs.ca.gov/services/ltc/Pages/Templates.aspx

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Applying parent organizations with pending multiple initial applications while this new requirement was being developed will be grandfathered in and their pending applications will not be impacted.

Overlapping service area

New applicants proposing to enter an area already served by an existing PO must identify the overlapping zip codes in their LOI. DHCS will immediately notify by email any existing and/or pending POs of the new applicant's intent, and the existing and/or pending POs will have an opportunity to submit their own market feasibility study in response. The counter-feasibility study must be submitted to DHCS within 30 days of the existing and/or pending PO receiving the email notification from DHCS. Overlapping service areas are determined at the zip code level. Therefore, if a PO is only servicing a portion of a county, and a new or expansion application is requesting a zip code not in the PO's service area, by zip code, then the new or expansion application would not trigger notification to the existing/pending PO for an overlapping service area competing market feasibility study.

DHCS will conduct its own market feasibility study using Medi-Cal data to verify the market feasibility studies that applicants/POs submit. DHCS will evaluate actual numbers of Medi-Cal beneficiaries by age and aid code and will use historical trends of clinical eligibility and market capture to compare against market analyses submitted by applicants/existing PO's.

Letters of Opposition

DHCS will acknowledge receipt of any letters of opposition submitted as part of the counter analysis process. DHCS does not place significant weight on letters of opposition, however all letters will be documented and taken into consideration.

Restrictions on Delegation

This PACE Policy Letter clarifies the PACE delegation restrictions set forth in previous DHCS PACE Policy Letters. DHCS prohibits existing and applicant POs from delegating or subcontracting the operation and staffing of existing and/or additional (expansion) PACE Centers and IDTs to a separate entity.

POs are responsible for coordinating and delivering the medical and long-term care of frail and vulnerable elderly Californians so that they can remain living safely in their community rather than receiving institutional care. Because of the complexity of this responsibility, the Department prohibits any arrangements to delegate the administration of a PACE Center or PACE IDT to third parties. These DHCS concerns regarding delegation in the PACE model are reflected in the Responses of CMS to Comments presented in the Federal Register, Volume 71, No. 236, pages 71247 to 71263, and 71270 to 71272, regarding Title 42, Code of Federal Regulations, parts 460.60, 460.70, and 460.71.

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There is one existing delegated delivery model within PACE in California. The On Lok delegation contract with the Institute of Aging was originally established on August 1, 1996. This model was identified as a contractual arrangement in place on or before July 1, 2000 and was confirmed as "grandfathered" in by CMS in a January 15, 2002, letter. Grandfathering was necessary as the arrangement was not explicitly allowed under the PACE permanent provider regulations at that time.

While DHCS explicitly prohibits full delegation of the fundamental program elements of operation of the PACE Center and IDT, POs have the ability to subcontract for any service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a participant in their home/community are accessible by the PO. POs may enter into subcontracting agreements using the PACE Subcontract Boilerplate template provided by DHCS. Any amendments to the boilerplate template require the Department's prior written approval.

All approved subcontracts need to be in place with signed contract agreements prior to the scheduled go-live date. Pending subcontracts must have the approval for extension granted by DHCS to be signed no later than 1 month after the go live date.

Please note that DHCS' prohibition on the use of delegation in PACE does not impact POs option to utilize alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the participant's home, an inpatient facility, or PACE Center. A PACE participant receives some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center and all PACE participants receiving services at an ACS must be assigned to a PACE Center and IDT.

POs in County Organized Health System and Single Plan Model Counties

Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county. Specifically, Welfare & Institutions code 14087.5 et seq. provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services in those counties. DHCS will only consider the operation of a third-party PO in a COHS county if the applicant includes a letter of support from the COHS that includes a statement from the COHS that the COHS supports the establishment of the independent PO in the county, and verification of the COHS' concurrence with the applicant's proposed service area. The COHS letter of support must be signed by the COHS' Chief Executive Officer, Chief Financial Officer, or the Chief Operational Officer.

The COHS letter of support must be included with the LOI submitted by the applicant organization signifying its intent to expand into a COHS county or to start a new PO in a COHS county. A separate letter of support from the County Board of Supervisors is not required. Based on the provided information, DHCS will decide whether to move forward with a non COHS PACE application in a COHS county. If DHCS approves operation of a non COHS PO in a COHS county, the non COHS PO must contract

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directly with DHCS and CMS as the PACE entity in the three-way program agreement. DHCS will not allow a COHS to contract with DHCS and CMS as the PACE entity in the three-way program agreement and then delegate operation of the PO to a separate entity.

The same rules apply to Single Plan Model Counties.

Licensing

With the implementation of AB 1128, primary care clinics, home health agencies, and adult day health centers (whether or not they are operated by a PO) that are providing services solely to PACE participants fall under the oversight and regulation authority of DHCS (W&I 14592(c)). POs should refer to the DHCS Policy Letter "DHCS Approval Process for Operating Primary Care Clinics, Adult Day Health Care centers, and Home Health Agencies under AB-1128" for details on the DHCS authority requirements under the AB 1128 process.

Primary care clinics, home health agencies, and adult day health centers (whether or not they are operated by a PO) that are providing services to a mixed population are subject to the authority of the California Department of Public Health (CDPH) licensing process.

PACE Centers must maintain a Primary Care Clinic (PCC) License and an Adult Day Health Center (ADHC) License. PO's must also choose to either maintain a Home Health Agency (HHA) License or contract with a licensed HHA for home health services. Health & Safety Code section 100315 allows DHCS, CDPH, the California Department of Social Services and the California Department of Aging to authorize exemptions to a PO from specific licensing requirements for clinics, ADHC centers, Community Care Licensing facilities, and HHAs that are duplicative, conflicting, or inconsistent with PO requirements. Applicants should consult with the appropriate licensing entity to verify licensing requirements and anticipated timelines.

For-profit entities applying to become a PO do not qualify to be licensed as a PCC as defined under H&S Code section 1204, Such a PO's PCC must comply with the standards set forth in Welfare & Institutions Code section 14592(c), and are subject to oversight and regulation by DHCS.

For POs that fall under the DHCS authority, the onsite and desk review of PCC, ADHC, and HHA standards will occur concurrently with the SRR of the PACE center. CMS will not accept the SRR until all required licenses are secured.

CDPH Licensure applications can be found on the CDPH website.[8]

[8] https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/ApplyForLicensure.aspx

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Replacement PACE Centers

Existing PO's may move locations or consolidate PACE Center sites by constructing a replacement PACE Center. This scenario is distinct from the construction of a new PACE Center, which requires the submission of a Service Area Expansion application. Replacement Centers require the following transition planning items:

- Administrative Notifications: Notify CMS and DHCS at least 120 days prior to projected transition date.
- Transition Plan: PO's must submit a detailed transition plan that outlines the occupancy timeline, replacement center capacity, contingency planning, transportation plan, notification to participants, and details of any changes in staffing, policies and procedures, etc.

A PO seeking to replace its PACE Center(s) should refer to CMS guidance released on October 21, 2016 that provides further detail on the requirements for transition. Replacement Centers are not subject to the January 1 or July 1 start dates.

The new application process policies within this updated PL will become effective on the quarter following the final release of this PL.

If you have any questions regarding the requirements of this Policy Letter, please contact your Integrated Systems of Care, PACE Contract Manager.

Sincerely,

DocuSigned by:
Cortney Maslyn
30016FCE843D430...
Cortney Maslyn, Chief
Integrated Systems of Care Division
Department of Health Care Services

Enclosures

Attachment I
Attachment II
Attachment III

CalOptima Health

Policy:	PA.9003
Title:	**PACE Letters of Support**
Department:	CalOptima Health PACE
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/07/2025
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☒ PACE

For 20250807 BOD Review Only

I. PURPOSE

This policy defines the process for organizations to request a letter of support from CalOptima Health as required to apply to the Department of Health Care Services (DHCS) to establish a new third-party Program of All-Inclusive Care for the Elderly (PACE) Organization (PO) independent of CalOptima Health's PACE program, or to expand an existing PO's service area in Orange County.

II. POLICY

A. As a County Organized Health System (COHS), CalOptima Health is the sole source for Medi-Cal services in Orange County. Welfare & Institutions Code (WIC) Section14087.5 et seq. provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services, including PACE. Department of Health Care Services (DHCS) Policy Letter (PL) 23-01: Program of All-Inclusive Care for the Elderly Application Process requires entities submitting applications to establish a new PO or expand an existing PO's service area in COHS counties like Orange County to submit a letter of support from CalOptima Health in their application.

B. DHCS policy requires that letters of support from COHS plans must include a statement of explicit support for the establishment of the independent PO, and verification of concurrence with the applicant's proposed service area.

C. Entities that submit a request are not guaranteed a letter of support from CalOptima Health. CalOptima Health reserves the right to deny any request from an entity seeking to establish a new PO or expand service area at its sole and absolute discretion. Nothing in this policy is intended to indicate the entity requesting a letter of support is guaranteed to be approved.

D. A prospective PO must submit a formal request for a letter of support, complete an application, and meet all the criteria included in the Procedure section of this policy for CalOptima Health to consider the request.

E. CalOptima Health will not accept requests from entities proposing to establish a new PO that covers a service area that includes all zip codes in Orange County.

Back to Agenda Back to Item

F. CalOptima Health will only consider requests for a letter of support to establish a new PO from entities that are organized as non-profit entities and are wholly owned and controlled by a non-profit parent entity.

G. CalOptima Health will verify that the applicant is in good standing which includes but is not limited to:

1. The applicant and any parties that make up the proposed PO, the parent entity, any affiliated entities under common ownership or otherwise related to the proposed PO may not be on a Medicaid/Medicare exclusion list, as outlined in CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring.

2. Any Medicaid/Medicare line of business operated by the applicant or affiliated entities cannot be under sanctions or facing civil monetary penalties from any local, state, or federal government entity.

H. Letters of support are subject to approval by the CalOptima Health Board of Directors, which must be submitted directly to DHCS and will be signed by CalOptima Health's Chief Executive Officer (CEO), the Chief Operating Officer (COO), or the Chief Financial Officer (CFO).

I. Letters of support provided by CalOptima Health to new independent POs are not intended to create nor shall they be deemed or construed to create any relationship between the new independent PO and CalOptima Health, or CalOptima Health's PACE organization.

III. PROCEDURE

A. Submission and Review of Formal Requests for Letter of Support Requests and Required Applications and Documents

1. Entities seeking letters of support from CalOptima Health must submit a formal written request to CalOptima Health's Chief Executive Officer via email or other written form signed and dated by the requesting Chief Executive Officer, or designee, with the authority to make decisions on behalf of the applicant entity that is establishing the proposed PO or expanding an existing PO.

2. Formal written requests must specifically state the nature of the request and include specific information applicable to the request.

a. When requesting a letter of support for an application to DHCS to establish a new PO in Orange County, the requesting entity must submit the following information in their formal written request:

i. Identify the specific zip codes planned to be served.

ii. Identify the zip codes that overlap with any existing POs and potential POs with pending applications.

iii. A transportation plan that demonstrates the proposed PO's ability to serve all requested zip codes from the PACE center location(s) to and from the prospective Participants' home in less than 60-minute per one-way drive.

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b. When requesting a letter of support for an application to DHCS to expand an existing PO's service area, the requesting entity must submit the following information in their formal written request:

i. Identify specific expansion zip codes;

ii. Identify zip codes that overlap with any other existing operational POs and potential POs with pending applications; and

iii. A transportation plan that demonstrates the proposed PO's ability to serve all requested zip codes from the PACE center location(s) to and from the prospective Participants' home in less than 60-minute per one-way drive.

3. CalOptima Health's Executive Director of Medicare Programs shall review the request within fifteen (15) business days of receipt of the request and present a recommendation to CalOptima Health Executive leaders.

B. If CalOptima Health leaders determine that the initial request meets the Board of Director's strategic objectives for serving Orange County PACE eligible residents, the Executive Director of Medicare Programs will send a written response informing the entity requesting a letter of support of CalOptima Health's decision.

1. If the request is approved, the applicant will be informed of the requirements to move forward with the application process.

2. If the request is denied, the Executive Director of Medicare Programs will respond to explain the specific reason for the denial.

C. Application and Documentation

1. Entities requesting a letter of support from CalOptima Health must complete an application that shall include the following elements and supporting documentation.

a. Primary Criteria (50% weighting)

i. Potential impact on CalOptima Health PACE operations and other POs operating in Orange County.

ii. Evaluation of overlap with existing POs in the Orange County (e.g., also considering likelihood of adverse member selection, member confusion, geographic separation, etc.).

iii. Evaluation of prospective PO's application demonstrates that they are proposing to offer complementary services to existing POs in Orange County including but not limited to:

a) Services to unique member populations, serving remote or underserved geographic areas of Orange County;

b) Bringing new Providers into the PACE system; or

For 20250807 BOD Review Only

c) Other meaningful ways of expanding or enhancing services to Orange County PACE eligible beneficiaries.

b. Threshold Criteria (50% weighting): All letters of support applications shall include and will be evaluated based on the following criteria:

i. PACE Operating Experience:

a) Must demonstrate a minimum of five (5) years of operating experience in California;

b) Provide documentation of DHCS or Centers for Medicare & Medicaid Services (CMS) regulatory audits with no sanctions;

c) Submit PACE operational policies and procedures; and

d) Obtain reference letters from member advocates, providers and community stakeholders unaffiliated or who have no financial interest in the entity applying for a letter of support.

ii. Financial Soundness:

a) Submit financial statements (income statements and balance sheets) for the three (3) most recent consecutive years;

b) Report on financial metrics (i.e., liquidity, debt ratio, short-term viability, delinquency); and

c) Obtain third-party risk report via Dunn and Bradstreet (where available).

iii. Quality Performance/Metrics:

a) Report on performance against current CalPACE averages in areas of Participants residing in nursing homes, hospital admissions, hospital days, hospital readmission rate, emergency room visits and Participant satisfaction rating;

b) Results of their most recent Integrated Satisfaction Measurement for PACE (I-SAT) survey;

c) Latest DCHS and CMS audit report and findings;

d) Current Fiscal year report on number of Grievances by type; and

e) PACE Annual quality metrics.

iv. Demographic Competence:

a) Provide a general PACE demographic profile data of the ZIP code area of interest.

b) Demonstrate experience and qualifications of staff serving PACE participants in the potential geographic area including:

1) Training in cultural competency;

For 20250807 BOD Review Only

2) Language capability;

3) Accommodation for low literacy; and

4) Response to socioeconomic factors.

D. Initial Review

1. Upon verifying the requesting entity is not excluded or precluded from participating in a federally-funded healthcare program, the prospective request for a letter of support will be reviewed.

2. If the documentation does not meet the requirements, the CalOptima Health Executive Director of Medicare Programs shall notify the applicant of the deficiency and denial of application.

E. CalOptima Health Review Team

1. If the entity requesting a letter of support meets the requirements and all required documentation is received, the Executive Director of Medicare Programs shall forward the prospective PO application packet to the CalOptima Health review team. The team will review and score the documents in accordance with the instructions on the scoring tool. The CalOptima Health review team will review and tally the scores and will make a recommendation.

2. If the review team determines that the applicant is eligible for a letter of support, CalOptima Health's Executive Director of Medicare Programs shall present the findings to CalOptima Health's Executives.

3. Executive leaders will present a recommendation as a CalOptima Health Board Action Referral (COBAR) to the CalOptima Health Board of Directors for approval. The Board of Directors may approve or deny the request.

F. If the Board of Directors approves issuing a letter of support on behalf of the requesting organization, the Executive Director of Medicare Programs will draft a letter for the CEO, COO or CFO to sign, submit directly to DHCS, and provide a copy to the applicant for their Letter of Intent (LOI) submission to DHCS.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Welfare & Institutions Code (WIC), Section 14087.5
B. Department of Health Care Services (DHCS) Policy Letter (PL) 23-01: Program of All-Inclusive Care for the Elderly Application Process
C. CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

For 20250807 BOD Review Only

VII. BOARD ACTION(S)

Date	Meeting
08/07/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/07/2025	PA.9003	PACE Letters of Support	PACE

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IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
County Organized Health System (COHS)	Medi-Cal health plan that is run by a county government entity and is the sole Medi-Cal heath plan operation in the county without enrollment limits
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program.
Grievance	A complaint, either oral or written, expressing dissatisfaction with service delivery or the quality of care furnished, regardless of whether remedial action is requested as defined by the federal PACE regulation 42 CFR Section 460.120.
Participant	An individual enrolled in the CalOptima Health PACE program.
Program of All-Inclusive Care for the Elderly (PACE)	PACE is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.

For 20250807 BOD Review Only

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Approval of Process for Considering Requests for Letters of Support from Organizations Seeking to Offer Program of All-Inclusive Care for the Elderly (PACE) Services in Orange County Independent of CalOptima

Contact

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

Recommended Action

Authorize the CEO to implement a process to consider requests for letters of support from organizations seeking to offer PACE services in Orange County independent of CalOptima, with all final decisions subject to Board approval.

Background

PACE is a comprehensive health care program that CalOptima provides for frail seniors in Orange County. The PACE model is a person-centered, community-based alternative to nursing home care. PACE supports elders and their families by providing preventive and primary care, and coordinating behavioral health and acute care, as well as long-term services and supports. The intensive care coordination helps individuals with complex chronic care needs to continue living in the community as long as possible. CalOptima opened Orange County's first PACE center in October 2013, and the program has grown to nearly 300 participants. CalOptima recently launched several new initiatives designed to expand access to PACE, including partnerships with Community-Based Adult Services (CBAS) centers, a greater role for community-based physicians in caring for PACE participants, and a larger PACE service area to reach all eligible seniors in Orange County.

On October 27, 2017, and on August 17, 2018, the Department of Health Care Services (DHCS) issued PACE policy letters regarding the PACE application process, including guidance on operation of an independent PACE facility in County Organized Health System (COHS) counties including Orange County. Historically, the only entity that could operate a PACE program in a COHS county was the designated Medi-Cal managed care plan. Welfare & Institutions code section 14087.5 *et seq*. provides that a managed care plan that elects to organize as a COHS holds the exclusive right to contract for Medi-Cal services, including PACE, in the respective county.

However, the above-referenced DHCS policy letters describe a process by which an organization interested in becoming an independent PACE Organization (PO) in a COHS county may, with the formal support of the local COHS plan, be considered to operate in that county(s). Specifically, DHCS will only consider an application from an independent PO in a COHS county if its application to DHCS includes a letter of support from the COHS Medi-Cal managed care plan. In the letter, the COHS plan must take the significant step of requesting that DHCS submit a formal request to the federal Centers for Medicare & Medicaid Services (CMS) requesting an amendment to California's existing Section 1115 Medicaid Waiver as part of the independent PO application process to make an exception to the existing

law that governs COHS plans. COHS plans, including CalOptima, are under no obligation to provide such letters of support.

Specific to the application process for organizations seeking to operate in COHS counties, the COHS plans' only role is to issue (or not issue) a letter of support. If the COHS plan does not issue a letter of support, DHCS will not approve the application; if the COHS does provide a letter of support, it will be up to state and federal regulators to make all subsequent decisions on the application.

Since the release of the DHCS policy letters, staff has received informal inquiries from groups interested in applying to become independent POs in Orange County on how and whether CalOptima intends to respond to any requests for letters of support requesting that DHCS seek formal modification of California law governing the COHS framework.

Should CalOptima decide to provide one or more letters of support to independent POs, the decision would then be out of CalOptima's hands, and the independent POs would follow an application process first involving DHCS, and if DHCS submits the request, CMS would consider whether to approve the requested waiver amendment. If CMS approves the waiver amendment, DHCS would then evaluate the independent PO application, and if approved, the application would go to CMS for final approval.

Separate from considering requests from independent POs, CalOptima staff is continuing Board-approved expansion efforts through collaboration with community partners. These include expanding CBAS center use through Alternative Care Setting sites, continuing to cultivate referrals from contracted community-based physicians, enrollment efforts in South Orange County, increasing current sales and marketing efforts, adding a Veteran's Choice option to encourage enrollment by veterans, and adding a Medicare-only members option.

Discussion

In response to the DHCS policy letters and independent PO inquiries, staff is recommending that the Board approve an internal review process for the evaluation of requests for letters of support from organizations seeking to establish independent PACE operations in Orange County and making recommendations to the Board.

Elements of the process to consider letter of support requests include, but are not limited to:

1. **Application timeline window:** Subject to Board approval, staff anticipates accepting letters of support requests beginning November 1, 2018, to January 31, 2019.
2. **Geographic ZIP code designation:** Consistent with the DHCS and CMS PACE organization application process and policy, independent PO letter of support requests will include the specific ZIP codes the independent PO is interested in serving.
3. **Threshold Criteria (~~20~~50% weighting):** All letter of support requests from independent POs shall include and will be evaluated based on the following criteria:
    a. PACE operating experience
        i. Show a minimum of five (5) years of operating experience
        ii. Provide proof of regulatory audits with no sanctions

Rev. 9/6/18

iii. Submit operational policies and procedures
iv. Obtain reference letters from member advocates, providers and community stakeholders

b. Financial soundness
   i. Submit financial statements (income statements and balance sheets) for the three most recent consecutive years
   ii. Report financial metrics (i.e. liquidity, debt ratio, short-term viability, delinquency)
   iii. Obtain third-party risk report via Dunn and Bradstreet (where available)

c. Quality performance/metrics
   i. Report performance against current CalPACE averages in areas of participants residing in nursing homes, hospital admissions, hospital days, hospital readmission rate, emergency room visits and participant satisfaction rating

d. Demographic competence
   i. Provide a general PACE demographic profile data of the ZIP code area of interest
   ii. Demonstrate staff experience and/or understanding in serving PACE participants similar to those in the potential geographic area
      1. Training in cultural competency
      2. Language capability
      3. Accommodations for low literacy
      4. Response to socioeconomic factors

4. **Primary Criteria (~~80~~ 50% weighting):** Potential impact on CalOptima PACE program/operations and other POs operating in Orange County, if any. Rev. 9/6/18
   a. For POs with strong demonstrated performance on the Threshold Criteria, the focus would be on, for example, evaluation overlap with existing PACE facilities in the County (e.g., also considering likelihood of adverse member selection, geographic separation, etc.); how the PO's application demonstrates that they are proposing to offer complementary PACE services (e.g., for unique member populations, serving remote/underserved geographic areas of the County, bringing new providers, or in some other meaningful ways, enhancing existing PACE facilities).

5. **Return to the Board with Recommendations**. After analyzing PO proposals and requests for letters of support, staff will return to the Board with recommendations.

Fiscal Impact

The recommended action is projected to be budget neutral. CalOptima's Fiscal Year 2018–19 Operating Budget, approved by the Board on June 7, 2018, included projected revenues and expenses related to the continuation of PACE expansion.

Staff anticipates that the administrative expenses included in the Board-approved operating budget are sufficient to cover the anticipated costs related to the recommended action.

Rationale for Recommendation

Staff recommends that the Board adopt a process for considering requests for letters of support from organizations seeking to offer PACE services in Orange County independent of CalOptima. As a public agency, CalOptima should be prepared to respond to such potential requests.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS PACE Policy Letter 17-03, issued on October 27, 2017.
2. DHCS PACE Policy Letter 18-01, issued on August 17, 2018.
3. Presentation: PACE Response to Regulatory Guidance

/s/ Michael Schrader — *8/29/2018*

Authorized Signature — **Date**

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Date: October 27, 2017

Policy Letter 17-03
Replacing PACE Policy Letter 16-01

To: Program for All-Inclusive Care for the Elderly (PACE) Organizations

Subject: PACE Application Process

Purpose

The purpose of this Policy Letter is to inform Program of All-Inclusive Care for the Elderly (PACE) Organizations (POs) and potential applicant organizations of the revised Department of Health Care Services (DHCS) application review process and timeline for new PO applications and PACE Expansion applications.

Background

In 2016, the California Legislature passed the PACE Modernization Act Trailer Bill (Sections 31-36 of SB 833, Chapter 30, Statutes of 2016) including updates to the payment and regulatory structure of PACE. The updated California PACE statutes, in part, removed the cap on the number of POs that could operate in the state, and allowed for-profit entities to become POs. As a result, DHCS has seen renewed interest in PACE and an increase in new/expansion applications submitted to DHCS for review. Therefore, DHCS is issuing revised guidance to clarify the Department's expectations with respect to the competitive nature of the review process.

The Centers for Medicare & Medicaid Services (CMS) released the 2017 PACE Application Guidance on January 17, 2017, to address its electronic PACE application submission timelines and review process. Effective immediately, all new and expansion PACE applications are required to be submitted to CMS through the web-based Health Plan Management System (HPMS). Applicants should review this guidance and be aware of CMS requirements for accessing HPMS. The downloadable PDF of the application and additional information can be found at: https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html

Application Review Process

All new and expansion PACE applications must go through an initial review process by DHCS in order to move forward with submission to CMS via HPMS. The initial submission components are detailed in this letter, which aims to provide DHCS with key organizational background and financial viability documentation. This information is necessary for the State to complete/sign the State Assurance pages and authorize the submission of the full application to DHCS and CMS via HPMS.

Upon submission of the full application to CMS, the State will align its review of the remaining application with the CMS initial 45/90-day clock cycle, dependent on type of application, to create a concurrent review process. The initial CMS 45/90-day clock review begins upon receipt of the completed full application in HPMS, which must include the signed State Assurance pages.

DHCS will review the application according to state and federal laws and regulations. Prior to entering into a contract for the provision of Medi-Cal managed health care services, DHCS may consider any factor it determines to be necessary for consideration (Welfare & Institutions Code §§ 14095 and 14592(b)). This includes considering any information relevant to the issue of whether the application could result in unnecessary duplication of services or impair the financial or service viability of an existing program (42 USCA § 1395eee(e)(2)(B)).

Initial State Review

All new and expansion applications received by DHCS will follow the below initial state review timeframes for application submission:

Action	**Due Date**	**Documents for Submission**	**Reviewer**	**Review Timeframe**
Notification of Intent to DHCS	30 days prior to Initial Application Submission to DHCS	• Letter of Intent • Letter for Support from COHS (if applicable)	DHCS	N/A
Initial Application Submission to DHCS	60 days prior to CMS application submission deadline	• Market Feasibility Study • Letters of Support • Application sections (see Attachment 1)	DHCS	60 Calendar Days
Full Application Submission in HPMS	Align with CMS PACE Application Submission Deadline	• Remaining application sections • State Assurance Page	DHCS/CMS	Align with CMS 45/90 day review clock

Concurrent Federal and State Review

The CMS review process of the PACE Application will include a series of attestations and uploads based on the type of application received, (Initial Application or Service Area Expansion).

Upon completion of the initial CMS 45/90-day clock review of the full application, CMS and/or DHCS may issue a Request for Additional Information (RAI) to the applicant. In the event a RAI is issued, the application is taken off the review clock during this period while the applicant responds to either the CMS and/or DHCS RAI. DHCS will align its remaining review and RAI (if necessary) with CMS timelines and ensure that any necessary changes are communicated to CMS.It is also during this period that DHCS conducts the Readiness Review (RR) onsite survey of the applicant PACE Center, as required. All initial applications and any Service Area Expansion (SAE) application that includes the addition of a new PACE center requires a RR of

the new center. All deficiencies that may be identified during the DHCS Readiness Review onsite survey of the applicant PACE Center must be addressed through a corrective action plan submitted and accepted by DHCS.

Once CMS and/or DHCS have accepted the applicant's RAI response and the Readiness Review onsite survey has been completed by DHCS and the applicant and accepted by CMS, CMS will reinitiate the final 45/90-day clock review cycle. Conclusion of this cycle results in CMS notification to the applicant of final approval or denial.

PACE Growth and Expansion

All PACE growth and expansion falls into one of the below categories:

New PACE Organization – New entity applying to establish a PO

- Entity must identify specific zip codes to be served in one or more counties
- Entity must be able to serve all requested zip codes from PACE Center (subject to 60-minute one way travel time adult day health center (ADHC) requirement)
- Rate development required for each county requested

Existing PO Expansion (Existing County) – PO adding additional zip codes within existing county service area, opening a new PACE Center within existing county service area, or both

- Entity must be able to serve all requested zip codes from PACE Center(s) (subject to 60-minute one way travel time ADHC requirement)
- POs can add zip codes and use Alternative Care Settings (ACS) and Community-based physician waiver as an interim step before building new PACE Center
- Consider rate development/adjustment to account for expansion within the county and account for potential variance and/or changes in utilization
- Zip code only expansions subject to shorter State/CMS review period

Existing PO Expansion (New County) – PO adding zip codes in a new county of operation

- Usually requires a new PACE Center unless the zip codes requested fall within the required radius to be served by existing PACE Center and interdisciplinary team (IDT)
- Requires new rate development

Program Start Date

To align with state budget and rate development processes, all new PO applications and expansion applications requiring new rate development will only be able to begin operations on either January 1 or July 1 of a given year following receipt of final approval from CMS and DHCS. Prospective POs and expansion applicants requiring new rate development should take the available start dates into consideration when preparing to submit an application. Any delays in the application submission or review process may result in the program start getting pushed back to the next available program start date of either January 1 or July 1.

Key Dates for CMS Application Submission

The downloadable PDF of the application and additional information such as application submission deadlines can be found at: https://www.cms.gov/Medicare/Health-Plans/PACE/Downloads/PACE_Application_Training_Feb_2017.pdf.

Initial Application Submission Components

Letter of Intent

All applicants must submit a Letter of Intent (LOI) to DHCS indicating their plans to submit a PACE application. The LOI should identify the applicant; the proposed service area, including a listing of proposed zip codes and a service area map; and the proposed site location for the applicant's PACE center. New applicants proposing to serve an area with an existing or pending PACE plan must identify the overlapping zip codes in their LOI. If an applicant has any questions about whether there is an existing or pending PO operating in its proposed service area it can refer to the DHCS PACE website for a listing of all zip codes by county that POs currently operate in at: http://www.dhcs.ca.gov/individuals/Pages/PACEPlans.aspx. Pending applications for new or expansion POs will also be posted to the DHCS website.

Based on the CMS application submission deadlines, LOI to DHCS would follow the below timeframes:

Letter of Intent to DHCS no later than…	**Initial Application Submission to DHCS no later than…**	**CMS Application Submission Deadlines *last business day of Quarter**
October 1, 2017	November 1, 2017	January 1, 2018
January 1, 2018	February 1, 2018	April 1, 2018
April 1, 2018	May 1, 2018	July 1, 2018
July 1, 2018	August 1, 2018	October 1, 2018

Letters of Support

All PACE applicants must submit letters of support from local entities in the area that the applicant proposes to serve. These may include but are not limited to County Board of Supervisors, County Health and Human Services (HHS) Director, local hospitals, Medi-Cal managed care plans, Independent Physician Associations (IPAs), Commission on Aging, Area Agencies on Aging (AAA), local Multipurpose Senior Services Program (MSSP) Waiver sites, etc. Letters of support should be attached to the LOI. The minimum requirements for letters of support in County Organized Health System counties is provided below.

Market Feasibility Study

All PACE applicants must submit a market analysis of the area that they propose to serve. The feasibility study should include the following:

- Estimate of the number of PACE-eligible individuals
- Description of the methodology/assumptions used to determine potential membership

- Identify all competitive factors impacting the market, such as:
  - Existing POs
  - Managed care plans (MCPs)
  - Demonstration County MCPs (Cal MediConnect and Managed Long-Term Services and Supports (LTSS))
  - Medi-Cal Waiver Programs
  - In-Home Supportive Services (IHSS)
- Identify projected market capture/saturation rates
- Demonstrate that there is an unmet need for PACE in the proposed service area
  - Please note that when multiple applications are received for the same county/zip code service area the order of submission and number of pre-existing plans may have an impact on the decision to approve / deny an application.

Application Narrative

The following PACE application sections must be submitted to DHCS for initial review (see Attachment 1):

New PACE Application	Service Area Expansion (Existing and New County)
• 3.1 – Service Area • 3.2 – Legal Entity and Organization Structure • 3.3 – Governing Body • 3.4 – Fiscal Soundness	• 3.1 – Service Area • 3.4 – Fiscal Soundness • 3.5 – Marketing • 3.13 – Contracted Services • 3.23 – Transportation Services

In addition to the attestations and documents required in the PACE application, DHCS requires detailed narrative in each of these sections to better understand the organizational background and financial standing of the applicant.

Additional Considerations and Limitations

Overlapping service area

New applicants proposing to enter an area already served by an existing PO must identify the overlapping zip codes in their LOI. DHCS will immediately notify any existing and/or pending POs of the new applicant's intent, and the existing and/or pending PO(s) will have an opportunity to submit their own market analysis in response. The counter-analysis must be submitted to DHCS by the initial application submission date. Overlapping service areas are determined at the zip code level. Therefore, if a PO is only servicing a portion of a county and a new or expansion application is requesting a zip code not in the POs service area, by zip code, then the new or expansion application would not trigger notification to the existing/pending PO for an overlapping service area competing market analysis.

DHCS will conduct its own analysis using Medi-Cal data to verify the market feasibility studies that applicants/POs submit. DHCS will evaluate actual numbers of Medi-Cal beneficiaries by age and aid code and will use historical trends of clinical eligibility and market capture to compare against market analyses submitted by applicants/existing POs.

DHCS, in consultation with other State Administering Agencies, has developed a review tool to assist in considering prospective PO applications and the overlapping service area they propose to enter. The review tool is included as Attachment II (Service Area Overlap Review Criteria) to this letter. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Restrictions on Delegation

DHCS is using this PACE Policy Letter to provide explicit clarification to its policy on the use of delegation in the PACE model. DHCS prohibits existing and applicant POs from delegating a separate entity to operate existing and/or additional (expansion) PACE Centers and IDTs. POs are responsible for coordinating and delivering the medical and long term care of frail and vulnerable elderly Californians so that they can remain living safely in their community rather than receiving institutional care. Because of the complexity of this responsibility, the Department has serious concerns with arrangements to delegate the administration of a PACE Center or PACE IDT to third parties. DHCS intends to amend its PACE contracts to include this prohibition. The validity of the DHCS concerns regarding delegation in the PACE model are reflected in the Responses of CMS to Comments presented in the Federal Register, Volume 71, No. 236, pages 71247 to 71263, and 71270 to 71272, regarding Title 42, Code of Federal Regulations, parts 460.60, 460.70, and 460.71.

There is one existing delegated delivery model within PACE in California. The On Lok delegation contract with the Institute of Aging was originally established on August 1, 1996. This model was identified as a contractual arrangement in place on or before July 1, 2000, and was confirmed as “grandfathered” in by CMS in a January 15, 2002, letter. Grandfathering was necessary as the arrangement was not explicitly allowed under the PACE permanent provider regulations at that time.

While DHCS explicitly prohibits full delegation of the fundamental program elements of operation of the PACE Center and IDT, POs have the ability to subcontract for any service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a participant in their home/community are accessible by the PO. POs may enter into subcontracting agreements using the PACE Subcontract Boilerplate template provided by DHCS. Any amendments to the boilerplate template require the Department’s prior written approval.

Please note that DHCS’ prohibition on the use of delegation in PACE does not impact POs option to utilize alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the participant’s home, an inpatient facility, or PACE Center. A PACE participant receives some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center and all PACE participants receiving services at an ACS must be assigned to a PACE Center and IDT.

POs in County Organized Health System Counties

Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county. Specifically, Welfare & Institutions code §14087.5 et seq. provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services in those counties. DHCS will only consider the operation of a

third party PO in a COHS county if the applicant includes a COHS' letter of support that includes the following:

- The COHS's support for the establishment of the independent PO in the county, and;
- The COHS request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county.

The COHS letter of support should be included with the LOI submitted by the applicant organization signifying its intent to expand into a COHS county or to start a new PO in a COHS county. DHCS will ultimately decide whether to move forward with a PACE applicant in a COHS and recommend an 1115 Waiver amendment. Any recommendation from DHCS will be subject to CMS review and approval. In the instance that independent operation of a third party PO is approved, the third party PO must contract directly with the State (DHCS) and CMS as the PACE entity in the three-way program agreement. It is not acceptable for the COHS to contract with DHCS and CMS as the PACE entity in the three-way program agreement and delegate operation of the PO to a separate entity.

This policy reflects the process that was utilized to approve the operation of Redwood Coast PACE in Humboldt County. Redwood Coast PACE was approved to operate independently from the COHS because its PACE application was submitted and accepted prior to the launch of the rural Medi-Cal managed care expansion. The COHS (Partnership Health Plan) endorsed the Redwood Coast PACE application and the exception was made possible by an amendment to California's existing 1115(a)(1) Bridge to Reform Demonstration Waiver.

Licensing

PACE Centers must maintain both a Primary Care Clinic License and an ADHC License. POs must also choose to either maintain a Home Health Agency (HHA) License or contract with a licensed HHA for home health services. Assembly bills 847 (Chapter 315 of 2005) and 577 (Chapter 456 of 2009) established the authority for CDPH/DHCS to authorize exemptions to a PO from licensing and regulatory requirements applicable to clinics, adult day health care services, and home health agencies. If requesting exemption from licensure, a PO must maintain at least one of the PACE Center required licenses (Clinic or ADHC) for each PACE Center. Applicants should consult with the California Department of Public Health (CDPH) to verify licensing requirements. CMS will not accept State Readiness Review until all required licenses are secured. Licensure applications can be found at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/ApplyForLicensure.aspx .

Replacement PACE Centers

Existing POs may move locations or consolidate PACE Center sites by constructing a replacement PACE Center. This scenario is distinct from the construction of a new PACE Center, which requires the submission of a service area expansion application. Replacement Centers require the following transition planning items:

- Administrative Notifications: Notify CMS and DHCS at least 120 days prior to projected transition date.
- Transition Plan: PO's must submit a detailed transition plan that outlines the occupancy timeline, replacement center capacity, contingency planning, transportation plan,

notification to participants, and details of any changes in staffing, policies and procedures, etc.

POs seeking to replace its PACE Center(s) should refer to CMS guidance released on October 21, 2016 that provides further detail on the requirements for transition.

If you have any questions regarding the requirements of this Policy Letter, please contact your Integrated Systems of Care contract manager.

Sincerely,

Jacey Cooper, Acting Division Chief
Integrated System of Care Division

Enclosures

Attachment 1
Attachment 2

Attachment I - PACE Application Required Attestations and Uploads

Attestation Topic	Section #	Initial	SAE	Upload Required (Initial)	Upload Required (SAE)
Service Area	3.1	X	X	X	X
Legal Entity and Organizational	3.2	X		X	
Governing Body	3.3	X		X	
Fiscal Soundness	3.4	X	X	X	X
Marketing	3.5	X	X	X	X
Explanation of Rights	3.6	X		X	
Grievance	3.7	X		X	
Appeals	3.8	X		X	
Enrollment	3.9	X		X	
Disenrollment	3.10	X		X	
Personnel Compliance	3.11	X			
Program Integrity	3.12	X			
Contracted Services	3.13	X	X		
Required Services	3.14	X			
Service Delivery	3.15	X			
Infection Control	3.16	X			
Interdisciplinary Team	3.17	X			
Participant Assessment	3.18	X			
Plan of Care	3.19	X			
Restraints	3.20	X			
Physical Environment	3.21	X			
Emergency and Disaster Preparedness	3.22	X			
Transportation Services	3.23	X	X		
Dietary Services	3.24	X			
Termination	3.25	X		X	
Maintenance of Records & Reporting	3.26	X			
Medical Records	3.27	X			
Quality Assessment Performance Improvement	3.28	X		X	
State Attestations	3.29	X		X	X
Waivers	3.30	X		X (as applicable)	
Application Attestations	3.31	X	X	X	X
State Readiness Review	3.32	X	X (as applicable)	X	X (as applicable)

Attachment II: Service Area Overlap Review Criteria

This tool identifies criteria that DHCS will take into consideration when evaluating applications requesting overlap of existing PACE service areas. DHCS is not limited to the use of only this criteria and will take under consideration additional factors as it determines appropriate to fully assess the application. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Category	Subcategory	Criteria
Service Area Overlap with Existing PACE Operator	Service Area Overlap	Overlap includes less than 25% of potential participants in existing service area
		Overlap includes between 25% and 50% of potential participants in existing service area
		Overlap includes between 50% and 75% of potential participants in existing service area
		Overlap includes over 75% of potential participants in existing service area
	Facility Overlap	Proposed service area includes existing PACE facility or alternative care setting
		Proposed service area does not include existing PACE facility or alternative care setting
Level of Success & Investment of Existing PACE Operators/ Applicants	Market Penetration of Existing Operators in Proposed Service Area	Market penetration under 10%
		Market penetration between 10% and 30%
		Market penetration over 30%
	Recent Investments by Existing PACE Operator(s) and Recent Applicant(s) in Proposed Service Area	Facility investment over $5M in the past year
		Facility investment over $5M between 1 and 2 years
		Facility investment over $5M between 2 and 3 years
		No facility investments over $5M in last 3 years
Local Support	Local Government Support	Formal vote of city council or comparable body in support of new applicant
		Letter of support from city council member or comparable official
		No written support from local government official
	Local Service Provider Involvement	Lead applicant is a services provider in proposed service area
		Supporting applicant is a services provider in proposed service area
		No part of applying entity is services provider in proposed service area

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Date: August 17, 2018

Policy Letter 18-01
Supersedes PACE Policy Letter 17-03

To: Program for All-Inclusive Care for the Elderly (PACE) Organizations

Subject: PACE Application Process

Purpose

The purpose of this Policy Letter is to inform Program of All-Inclusive Care for the Elderly (PACE) Organizations (POs) and potential applicant organizations of the updated Department of Health Care Services (DHCS) application review process and timeline for new PO applications and PACE Expansion applications.

Background

In 2016, the California Legislature passed the PACE Modernization Act Trailer Bill (Sections 31-36 of SB 833, Chapter 30, Statutes of 2016) including updates to the payment and regulatory structure of PACE. The updated California PACE statutes, in part, removed the cap on the number of POs that could operate in the state, and allowed for-profit entities to become POs. As a result, DHCS has seen renewed interest in PACE and an increase in new/expansion applications submitted to DHCS for review. Therefore, DHCS is issuing revised guidance to clarify the Department's expectations with respect to the competitive nature of the review process.

The Centers for Medicare & Medicaid Services (CMS) releases annual updates to its PACE Application Guidance to address its electronic PACE application submission timelines, requirements, and review process. Applicants should review this guidance and be aware of CMS requirements for accessing HPMS. The downloadable PDF of the application and additional information can be found at:
https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html

State Application Review Process

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necessary for the State to complete/sign the State Assurance pages and authorize the submission of the full application to DHCS and CMS via HPMS.
Upon submission of the full application to CMS, the State will align its review of the remaining application with the CMS initial 45/90-day clock cycle, dependent on type of application, to create a concurrent review process. The initial CMS 45/90-day clock review begins upon receipt of the completed full application in HPMS, which must include the signed State Assurance pages.

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Once CMS and/or DHCS have accepted the applicant's RAI response and the Readiness Review onsite survey has been completed by DHCS and the applicant and accepted by CMS, CMS will reinitiate the final 45/90-day clock review cycle. Conclusion of this cycle results in CMS notification to the applicant of final approval or denial.

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CMS application submission deadlines can be found under the application training guide here: https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html. The LOI to DHCS must be submitted at least 90 days prior to the proposed CMS submission date and the initial application must be submitted at least 60 days prior to the proposed CMS submission date.

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DHCS is using this PACE Policy Letter to provide explicit clarification to its policy on the use of delegation in the PACE model. DHCS prohibits existing and applicant POs from delegating a separate entity to operate existing and/or additional (expansion) PACE Centers and IDTs. POs are responsible for coordinating and delivering the medical and long term care of frail and vulnerable elderly Californians so that they can remain living safely in their community rather than receiving institutional care. Because of the complexity of this responsibility, the Department has serious concerns with arrangements to delegate the administration of a PACE Center or PACE IDT to third parties. DHCS intends to amend its PACE contracts to include this prohibition. The validity of the DHCS concerns regarding delegation in the PACE model are reflected in the Responses of CMS to Comments presented in the Federal Register, Volume 71, No. 236, pages 71247 to 71263, and 71270 to 71272, regarding Title 42, Code of Federal Regulations, parts 460.60, 460.70, and 460.71.

There is one existing delegated delivery model within PACE in California. The On Lok delegation contract with the Institute of Aging was originally established on August 1, 1996. This model was identified as a contractual arrangement in place on or before July 1, 2000, and was confirmed as "grandfathered" in by CMS in a January 15, 2002, letter. Grandfathering was necessary as the arrangement was not explicitly allowed under the PACE permanent provider regulations at that time.

While DHCS explicitly prohibits full delegation of the fundamental program elements of operation of the PACE Center and IDT, POs have the ability to subcontract for any service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a participant in their home/community are accessible by the PO. POs may enter into subcontracting agreements using the PACE Subcontract Boilerplate template provided by DHCS. Any amendments to the boilerplate template require the Department's prior written approval.

Please note that DHCS' prohibition on the use of delegation in PACE does not impact POs option to utilize alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the participant's home, an inpatient facility, or PACE Center. A PACE participant receives some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center and all PACE participants receiving services at an ACS must be assigned to a PACE Center and IDT.

POs in County Organized Health System Counties

Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county. Specifically, Welfare & Institutions code §14087.5 et seq. provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services in those counties. DHCS will only consider the operation of a third party PO in a COHS county if the applicant includes a COHS' letter of support that includes the following:

- The COHS's support for the establishment of the independent PO in the county, and;
- The COHS request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county.

The COHS letter of support should be included with the LOI submitted by the applicant organization signifying its intent to expand into a COHS county or to start a new PO in a COHS county. DHCS will ultimately decide whether to move forward with a PACE applicant in a COHS and recommend an 1115 Waiver amendment. Any recommendation from DHCS will be subject to CMS review and approval. In the instance that independent operation of a third party PO is approved, the third party PO must contract directly with the State (DHCS) and CMS as the PACE entity in the three-way program agreement. It is not acceptable for the COHS to contract with DHCS and CMS as the PACE entity in the three-way program agreement and delegate operation of the PO to a separate entity.

This policy reflects the process that was utilized to approve the operation of Redwood Coast PACE in Humboldt County. Redwood Coast PACE was approved to operate independently from the COHS because its PACE application was submitted and accepted prior to the launch of the rural Medi-Cal managed care expansion. The COHS (Partnership Health Plan) endorsed the Redwood Coast PACE application and the exception was made possible by an amendment to California's existing 1115(a)(1) Bridge to Reform Demonstration Waiver.

Licensing

PACE Centers must maintain both a Primary Care Clinic License and an ADHC License. POs must also choose to either maintain a Home Health Agency (HHA) License or contract with a licensed HHA for home health services. Assembly bills 847 (Chapter 315 of 2005) and 577 (Chapter 456 of 2009) established the authority for CDPH/DHCS to authorize exemptions to a PO from licensing and regulatory requirements applicable to clinics, adult day health care services, and home health agencies. If requesting exemption from licensure, a PO must maintain at least one of the PACE Center required licenses (Clinic or ADHC) for each PACE Center. Applicants should consult with the California Department of Public Health (CDPH) to verify licensing requirements. CMS will not accept State Readiness Review until all required licenses are secured. Licensure applications can be found at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/ApplyForLicensure.aspx .

Replacement PACE Centers

Existing POs may move locations or consolidate PACE Center sites by constructing a replacement PACE Center. This scenario is distinct from the construction of a new PACE Center, which requires the submission of a service area expansion application. Replacement Centers require the following transition planning items:

- Administrative Notifications: Notify CMS and DHCS at least 120 days prior to projected transition date.
- Transition Plan: PO's must submit a detailed transition plan that outlines the occupancy timeline, replacement center capacity, contingency planning, transportation plan, notification to participants, and details of any changes in staffing, policies and procedures, etc.

POs seeking to replace its PACE Center(s) should refer to CMS guidance released on October 21, 2016 that provides further detail on the requirements for transition. Replacement Centers are not subject to the January 1 or July 1 start dates.

If you have any questions regarding the requirements of this Policy Letter, please contact your Integrated Systems of Care contract manager.

Sincerely,

ORIGINAL SIGNED BY

Sarah Eberhardt-Rios, Division Chief
Integrated System of Care Division

Enclosures

Attachment 1
Attachment 2

Attachment I - PACE Application Required Attestations and Uploads

Attestation Topic	Section #	Initial	SAE	Upload Required (Initial)	Upload Required (SAE)
Service Area	3.1	X	X	X	X
Legal Entity and Organizational	3.2	X	X	X	X
Governing Body	3.3	X	X	X	X
Fiscal Soundness	3.4	X	X	X	X
Marketing	3.5	X	X	X	X
Explanation of Rights	3.6	X	X	X	X
Grievance	3.7	X	X	X	X
Appeals	3.8	X	X	X	X
Enrollment	3.9	X	X	X	X
Disenrollment	3.10	X	X	X	X
Personnel Compliance	3.11	X	X		
Program Integrity	3.12	X	X		
Contracted Services	3.13	X	X		
Required Services	3.14	X	X		
Service Delivery	3.15	X	X		
Infection Control	3.16	X	X		
Interdisciplinary Team	3.17	X	X		
Participant Assessment	3.18	X	X		
Plan of Care	3.19	X	X		
Restraints	3.20	X	X		
Physical Environment	3.21	X	X		
Emergency and Disaster	3.22	X	X		
Transportation Services	3.23	X	X		
Dietary Services	3.24	X	X		
Termination	3.25	X	X	X	X
Maintenance of Records &	3.26	X	X		
Medical Records	3.27	X	X		
Quality Assessment Performance Improvement	3.28	X	X	X	X
State Attestations	3.29	X	X	X	X
Waivers	3.30	X	X	X (as applicable)	
Application Attestations	3.31	X	X	X	X
State Readiness Review	3.32	X	X (as applicable)	X	X (as applicable)

Attachment II: Service Area Overlap Review Criteria

This tool identifies criteria that DHCS will take into consideration when evaluating applications requesting overlap of existing PACE service areas. DHCS is not limited to the use of only this criteria and will take under consideration additional factors as it determines appropriate to fully assess the application. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Category	Subcategory	Criteria
Service Area Overlap with Existing PACE Operator	Service Area Overlap	Overlap includes less than 25% of potential participants in existing service area
		Overlap includes between 25% and 50% of potential participants in existing service area
		Overlap includes between 50% and 75% of potential participants in existing service area
		Overlap includes over 75% of potential participants in existing service area
	Facility Overlap	Proposed service area includes existing PACE facility or alternative care setting
		Proposed service area does not include existing PACE facility or alternative care setting
Level of Success & Investment of Existing PACE Operators/ Applicants	Market Penetration of Existing Operators in Proposed Service Area	Market penetration under 10%
		Market penetration between 10% and 30%
		Market penetration over 30%
	Recent Investments by Existing PACE Operator(s) and Recent Applicant(s) in Proposed Service Area	Facility investment over $5M in the past year
		Facility investment over $5M between 1 and 2 years
		Facility investment over $5M between 2 and 3 years
		No facility investments over $5M in last 3 years
Local Support	Local Government Support	Formal vote of city council or comparable body in support of new applicant
		Letter of support from city council member or comparable official
		No written support from local government official
	Local Service Provider Involvement	Lead applicant is a services provider in proposed service area
		Supporting applicant is a services provider in proposed service area
		No part of applying entity is services provider in proposed service area

Back to Agenda Back to Item

PACE

CalOptima

A Public Agency

Better. Together.

PACE Response to Regulatory Guidance

Board of Directors Meeting

September 6, 2018

Phil Tsunoda, Executive Director, Public Policy and Public Affairs

Current PACE Landscape

- Alternative and new methods of expansion are in line with the national PACE growth initiative, known as PACE 2.0

- CalOptima PACE has a variety of expansion strategies in place
  - Alternative Care Settings
  - Community-based physicians
  - Service area expansion to south Orange County

- DHCS Policy Letters create an opportunity for independent PACE centers to operate in County Organized Health System (COHS) counties

DHCS Policy Letters

- October 2017 and August 2018 letters outline the policies affecting the application review process and timelines, as well as restrictions on delegation

- Of note to CalOptima, the policy letters require a letter of support from the COHS health plan as part of an independent PACE Organization (PO) application

DHCS Policy Letters (Cont.)

"DHCS will only consider the operation of an independent PO in a COHS county if the applicant includes a letter of support from the COHS stating:

- The COHS' support for the establishment of the independent PO in the county
- The COHS' request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county"

Regulatory Approval

- CalOptima's *only role* with regard to an independent PO applying to operate in a COHS county is *at the beginning*, in considering whether to issue a letter of support and associated 1115 Waiver amendment request
- Lengthy application process follows this sequence:
  1) Independent PO requests from COHS a letter of support, which includes the 1115 Waiver amendment request
  2) If letter of support is provided, independent PO submits to DHCS a letter stating its intent to apply to operate a PACE center
  3) DHCS considers whether to submit to CMS the waiver amendment request
  4) If DHCS submits, CMS considers whether to approve the waiver amendment request
  5) If CMS approves the waiver amendment, DHCS evaluates the independent PO application
  6) If DHCS approves the application, CMS evaluates the independent PO application

Process for Consideration of Letter of Support

- CalOptima proposes a fair and objective evaluation process that includes, but is not limited to, certain elements:

- Application timeline window
  - Independent POs may submit letter of support requests during the period of November 1, 2018, to January 31, 2019

- Geographic ZIP code designation
  - Independent POs must include the specific ZIP codes the PO is interested in serving within Orange County

Process for Consideration of Letter of Support (Cont.)

- Threshold Criteria (20%)
  1. Operating experience
  2. Financial soundness
  3. Quality performance
  4. Demographic competence

- Primary Criteria (80%)
  5. Potential impact to CalOptima PACE program

Criterion 1: Operating Experience

- Show a minimum of five years of experience operating a PACE center
- Provide evidence of regulatory audits with no sanctions
- Submit operational policies and procedures
- Obtain reference letters from member advocates, providers and community stakeholders

Criterion 2: Financial Soundness

- Submit financial statements for the three most recent consecutive years
  - Income statements
  - Balance sheets
- Report important financial metrics
  - Liquidity
  - Debt ratio
  - Short-term viability
  - Delinquency
- Obtain third-party risk report via Dunn and Bradstreet where available

Criterion 3: Quality Performance

- Report performance against current CalPACE averages
  - Participants residing in nursing homes
  - Hospital admissions per 1,000
  - Hospital days per 1,000
  - Hospital readmission rate
  - Emergency room visits per 1,000
  - Participant satisfaction rating

Criterion 4: Demographic Competence

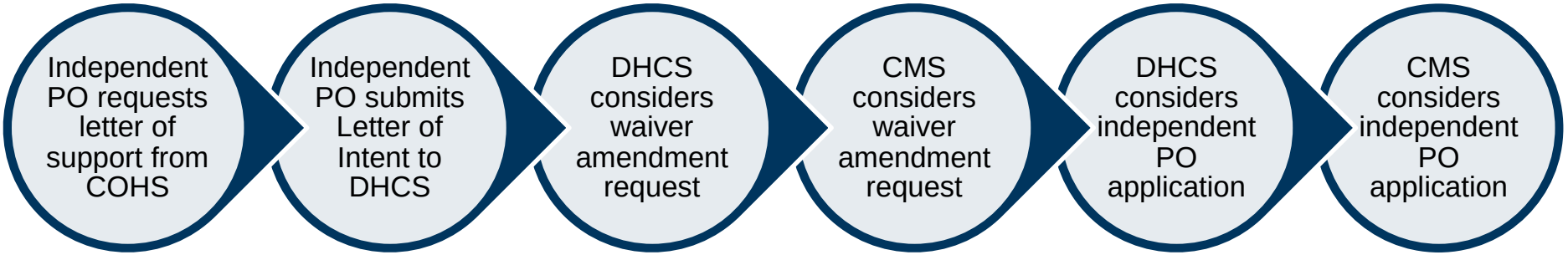
- Provide a general PACE demographic profile of the ZIP code area of interest

- Demonstrate staff experience/understanding in serving PACE participants similar to the potential participants in the geographic area of interest
  - Training in cultural competency
  - Language diversity and capability
  - Accommodations for low literacy
  - Response to socioeconomic factors

Criterion 5: Impact to CalOptima PACE

- State potential impacts of an independent PO on CalOptima's existing PACE program

PACE Application Process



If the application is approved, the independent PO would contract directly with DHCS and CMS

Recommended Actions

- Approve CalOptima PACE expansion strategy in response to state regulatory guidance.

- Authorize the CEO to implement a process to consider letters of support for qualified organizations seeing to establish an independent PACE facility in Orange County.
  - Staff to bring back for Board approval any recommendation regarding a letter of support for an independent PO letter.

INNOVATIVE INTEGRATED HEALTH, INC.

Phillip B. Tsunoda
Vice President, Government Relations

August 7, 2025

CalOptima Health Board of Directors
505 City Parkway West
Orange, CA 92868

**SUBJECT: SUPPORT FOR COBAR ITEM -
PACE LETTER OF SUPPORT POLICY PA 9003**

Dear Board Members,

Innovative Integrated Health (IIH), the owner and operator of Orange County PACE, respectively expresses its support for the proposed action item regarding CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE) Letter of Support policy PA 9003.

This policy will greatly assist in providing much needed health care and social service access to the significant PACE-eligible population in Orange County.

As you know, PACE provides a comprehensive program of health and wellness services for the county's frail, low-income senior population. Services include primary, preventative and acute medical care as well as social, recreational, nutritional and personal care services in a day center and clinic setting.

Through the PACE program, these services promote independence and enable participants to continue to live at home and in the community instead of residing in an institutional setting.

Because these services are vital for the continuation and enhancement of the quality of life for the vulnerable PACE population, Innovative Integrated Health (IIH) and Orange County PACE wholly supports this COBAR item.

Thank you for your attention.

Most sincerely,

Phillip Tsunoda
Vice-President, Government Relations

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 7, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

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

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions

Authorize the Chief Executive Officer, or designee, to execute amendments to the CalOptima Health Medi-Cal Fee-for-Service Hospital Services Contracts, effective October 1, 2025, to update:

1. Definition for Prior Authorization;
2. Definition for Utilization Management Program;
3. Language regarding determination of medically necessary covered services; and
4. Language related to assignment, assumption, and change of control.

Background and Discussion

CalOptima Health's hospital provider partners are a vital part of its delivery system and support CalOptima Health in providing care for its over 900,000 members. Amending the fee-for-service (FFS) hospital provider contracts is periodically necessary to address operational needs and to ensure CalOptima Health's delivery system operates in an efficient and effective manner.

The purpose of the amendment is to update the Medi-Cal FFS Hospital Services Contracts to address operational matters that have arisen with contracted FFS hospitals. The amendment clarifies certain existing language in those contracts to remove ambiguities with respect to prior authorizations, CalOptima Health's Utilization Management Program, medically necessary covered services, and requirements related to assignment, assumption, and change control.

Staff requests that the CalOptima Health Board of Directors authorize amending the FFS Hospital Services Contracts to reflect updated language in 4 sections of the contracts, as outlined in the attached amendment, ensuring a clear understanding of contractual requirements by all parties.

Fiscal Impact

The recommended action is operational in nature with no additional fiscal impact.

Rationale for Recommendation

The above recommended amendments serve to support CalOptima Health's delivery system and maintain a robust network.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Back to Agenda

Attachments

1. Entities Covered by this Recommended Board Action
2. Medi-Cal FFS Hospital Services Contract Amendment

/s/ Michael Hunn *07/31/2025*
Authorized Signature **Date**

Back to Agenda

Attachment to the August 7, 2025 Board of Directors Meeting – Agenda Item 16

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AHMC Anaheim Regional Medical Center	100 N. Stoneman Ave. 2nd floor, Managed Care Dept.	Alhambra	CA	91801
Alta Newport Hospital, LLC. dba Foothill Regional Medical Center	3824 Hughes Ave.	Culver City	CA	90232
Anaheim Community Hospital, LLC	3350 W. Ball Rd.	Anahiem	CA	92804
Anaheim Global Medical Center, Inc. dba Anaheim Global Medical Center	1301 N. Tustin Ave.	Santa Ana	CA	92705
Chapman Global Medical Center, Inc. dba Chapman Global Medical Center	1301 N. Tustin Ave.	Santa Ana	CA	92705
CHCM, Inc. dba College Hospital Costa Mesa	301 Victoria St.	Costa Mesa	CA	90627
Children's Hospital at Mission	1201 W. La Veta Ave.	Orange	CA	92868
Childrens Hospital of Los Angeles	4650 Sunset Blvd.	Los Angeles	CA	90027
Children's Hospital of Orange County	1201 W. La Veta Ave.	Orange	CA	92868
City of Hope National Medical Center	1500 E. Duarte Rd.	Duarte	CA	91010
College Hospital Inc. dba College Hospital Cerritos	10802 College Place	Cerritos	CA	90703
Encompass Health Rehabilitation Hospital of Tustin, L.P dba Encompass Health Rehabilitation Hospital Of Tustin	9001 Liberty Parkway	Birmingham	AL	35242
Hoag Memorial Hospital Presbyterian	One Hoag Dr.	Newport Beach	CA	92663
Keck Medical Center of USC dba Keck Hospital of USC	1500 San Pablo St.	Los Angeles	CA	90033
Keck Medical Center of USC dba USC Kenneth Norris Jr. Hospital	1441 Eastlake Ave.	Los Angeles	CA	90033
MemorialCare Long Beach Medical Center	2840 Long Beach Blvd., Suite 405	Long Beach	CA	90806
MemorialCare Long Beach Medical Center dba MemorialCare Miller Children's and Women's Hospital Long Beach	2840 Long Beach Blvd., Suite 120	Long Beach	CA	90806
MemorialCare Orange Coast Medical Center	209851 Brookhurst St., Suite 107	Huntington Beach	CA	92646

Back to Agenda Back to Item

Name	Address	City	State	Zip Code
MemorialCare Saddleback Medical Center	24451 Health Center Dr.	Laguna Hills	CA	92653
Mission Hospital Regional Medical Center dba Providence Mission Hospital	3345 Michelson Dr., Suite 100	Irvine	CA	92612
Orange County Global Medical Center, Inc. dba Orange County Global Medical Center	1301 N. Tustin Ave.	Santa Ana	CA	92705
Pomona Valley Hospital Medical Center	1798 N. Garey Ave.	Pomona	CA	91767
South Coast Global Medical Center, Inc. dba South Coast Global Medical Center	1301 N. Tustin Ave.	Santa Ana	CA	92705
Southern California Specialty Care, LLC dba Kindred Hospital - La Mirada	680 South Fourth St., KH-5	Louisville	KY	40202
Southern California Specialty Care, LLC dba Kindred Hospital - Santa Ana	680 South Fourth St., KH-5	Louisville	KY	40202
St. Joseph Hospital, Orange dba Providence St. Joseph Hospital	3345 Michelson Dr., Suite 100	Irvine	CA	92612
St. Jude Hospital Inc. dba Providence St. Jude Medical Center	3345 Michelson Dr., Suite 100	Irvine	CA	92612
THC - Orange County, LLC dba Kindred Hospital - Brea	680 South Fourth Street, KH-5	Louisville	KY	40202
THC - Orange County, LLC dba Kindred Hospital - Westminster	680 South Fourth Street, KH-5	Louisville	KY	40202
The Regents of the University of California, as described in Article IX, Section 9 of the California Constitution, on behalf of UC Irvine Medical Center	333 City Blvd., West Suite 200	Orange	CA	92868
UCSD Medical Center	200 W. Arbor Dr.	San Diego	CA	92103
University of California, Irvine dba UCI Health - Fountain Valley	1400 South Douglas Rd. Suite 250	Anaheim	CA	92806
University of California, Irvine dba UCI Health - Los Alamitos	1400 South Douglas Rd. Suite 250	Anaheim	CA	92806
University of California, Irvine dba UCI Health - Placentia Linda	1400 South Douglas Rd. Suite 250	Anaheim	CA	92806
VSC HBO, LLC dba Healthbridge Children's Hospital	393 S. Tustin St.	Orange	CA	92866
Whittier Hospital Medical Center Inc. dba Whittier Hospital Medical Center	100 N. Stoneman Ave., 2nd floor, Managed Care Dept.	Alhambra	CA	91801

Back to Agenda Back to Item

AMENDMENT No. X TO
AMENDED AND RESTATED HOSPITAL SERVICES CONTRACT

This Amendment No. X to the Amended and Restated Hospital Services Contract ("**Amendment**") is effective as of [insert date], 2025 ("**Effective Date**"), by and between Orange County Health Authority, a Public Agency, dba CalOptima ("**CalOptima**"), and [insert hospital name] ("**Hospital**"), with respect to the following:

RECITALS

A. CalOptima and Hospital entered into the Amended and Restated Hospital Services Contract ("**Contract**") under which Hospital has agreed to furnish certain items and services to CalOptima Members.

B. CalOptima and Hospital desire to amend certain terms of the Contract.

NOW, THEREFORE, the parties agree as follows:

1. Delete Section 1.49, *Prior Authorization*, of the Contract in its entirety and replace it with the following new Section 1.49, *Prior Authorization*:

   1.49 "Prior Authorization" means the written, telephonic, or deemed approval of CalOptima or its delegate for the provision or referral of Covered Services, other than Emergency Services, in accordance with CalOptima Policies, applicable laws, and this Contract. Any Prior Authorization remains subject to CalOptima's utilization management ("UM") determinations. Applicable laws, as used in this definition and elsewhere in the Contract, means any local, state, or federal statute, regulation, rule, or executive or agency order applicable to this Contract, including CalOptima's Regulators' operational guidance and other instructions related to the coverage, payment, and/or administration of CalOptima's programs. Any state or federal statute, regulation, rule, or executive or agency order that only applies to a certain CalOptima program(s) shall only be considered part of applicable laws with respect to the program(s) to which the state or federal statute, regulation, rule, or executive or agency order applies. Applicable laws do not include any state statute, regulation, rule, or executive or agency order preempted by federal law.

2. Delete Section 1.61, *UM Program*, of the Contract in its entirety and replace it with the following new Section 1.61, *UM Program:*

   1.61 "UM Program" means CalOptima's Utilization Management Program, which includes the utilization management or utilization review of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

3. Delete Section 2.3.4 of the Contract in its entirety and replace it with the following new Section 2.3.4 to the Contract:

   2.3.4 If there is a disagreement between CalOptima and the treating emergency physician regarding the Medical Necessity of Covered Services in an emergency, the judgment of the attending physician(s) caring for the Member at the treating facility shall prevail. CalOptima may (i) send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment, or (ii) arrange to have a Participating Provider agree to accept the transfer of the Member after the Member has Stabilized. The

attending physician actually treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on CalOptima.

4. Delete Section 9.1, *Assignment, Assumption, and Change of Control*, of the Contact in its entirety and replace it with the following new Section 9.1, *Assignment, Assumption, and Change of Control*:

9.1 Assignment, Assumption, and Change of Control. Hospital may not assign this Contract, either in whole or in part, without the prior written consent of CalOptima, which may be withheld in CalOptima's sole and absolute discretion. For purposes of this Section 9.1, assignment includes: (i) the change of more than fifty percent (50%) of the directors or trustees of Hospital; (ii) the merger, reorganization, or consolidation of Hospital with another entity when Hospital is not the surviving entity; or (iii) a change in the management of Hospital from management by persons appointed, elected or otherwise selected by the governing body of Hospital (*e.g.*, the Board of Directors) to a third-party management person or entity. In addition, Hospital must obtain CalOptima's prior written consent for any change of control. For purposes of this Section 9.1, a change of control includes the change of more than fifty percent (50%) of the ownership or equity interest in Hospital (whether in a single transaction or in a series of transactions).

5. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract.

IN WITNESS WHEREOF, CalOptima and Hospital have executed this Amendment:

FOR HOSPIAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 7, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

17. Ratify Amendment to Grant Award Agreement with Coalition of Orange County Community Health Centers for Population Health and Value-Based Care Transformation

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, (714) 954-2140

Recommended Action

Ratify the grant amendment with the Coalition of Orange County Community Health Centers for the Population Health and Value-Based Care Transformation to update terms and conditions related to payment, reporting, and other contract provisions.

Background and Discussion

On April 7, 2022, the CalOptima Health Board of Directors (Board) authorized the Chief Executive Officer (CEO) to launch a five (5)-year, $50 million initiative with community health centers to enhance access, quality, and further strengthen the safety net system across Orange County and appropriated up to $50 million from existing reserves to fund this effort. The Board also authorized the CEO to execute a grant agreement with Coalition of Orange County Community Health Centers (Coalition) to implement this initiative, with the specific aims to:

1. Enhance and strengthen primary care safety net quality infrastructure;
2. Enhance and strengthen safety net primary care delivery systems; and
3. Enhance and strengthen processes for people who receive, provide and lead care at health centers and partner organizations to support the goals of high value care.

CalOptima Health and the Coalition entered into a grant agreement on July 1, 2022, under which CalOptima Health will provide up to $10 million per year for five (5) years totaling $50 million to the Coalition to implement its proposed Population Health and Value-Based Care Transformation (PHVBC) initiative. The agreement is set to terminate on March 31, 2028, or upon completion of the project, whichever occurs last.

Based on progress reports from the Coalition, the first three years of the PHVBC initiative—consisting of one year of planning and two years of implementation—have focused on building the foundational systems, service lines, and supports necessary to strengthen participating health centers' capacity for population health management. Health center teams were given flexibility to identify the change ideas and priority areas most relevant to their patient populations and clinic contexts. They were expected to pilot these system enhancements and track progress using both outcome and process/intervention measures. In Year 3 of the grant program (health centers' second year of implementation work), participating health centers continued to refine and deepen their work.

Staff determined that the changes to the grant were limited in nature, as there were no changes to the scope of work or grant amount. In accordance with CalOptima Health Policy AA.1400: Grant Management, Section II.H., staff approved the requested change and executed the grant amendment on

Back to Agenda

July 10, 2025. The execution of the grant amendment allowed staff to provide a timely response to the close of Year 3 on June 30, 2025. The grant amendment included the following changes:

- CalOptima Health will apply unearned funds from Years 1 and 2 to offset expenditures in Year 3;
- New provisions were added regarding unauthorized use of funds, compliance with laws and policies, conflicts of interest, reports, monitoring, certificates of insurance, dispute resolution, and contract provision survival following termination;
- An updated Year 3 Work plan and Line-Item budget were added to the agreement;
- A new Grant Payment schedule was provided that includes language making future payments conditional on submission and acceptance of the coming year's Work plan and Line-item budget; and
- An updated Progress Report Schedule.

Update to Payment Terms

The following table provides a summary of grant expenditures and CalOptima Health's disbursement for Years 1 through 3. The grant amendment updated the Year 3 payment terms to apply the positive variance of $4.4 million from Years 1 and 2 and make a $4.3 million payment to cover the total Coalition Reported Expenditures of $8.7 million.

Grant Year/ Period	Coalition Reported Expenditures	CalOptima Health Disbursement	Variance
Yr 1 (7/1/22 – 6/30/23)	$7.9 million	$10.0 million	+$2.1 million
Yr 2 (7/1/23 – 6/30/24)	$7.7 million	$10.0 million	+$2.3 million
Yr 3 (7/1/24 – 6/30/25)	$8.7 million	$4.3 million	-$4.4 million
Subtotal (Years 1 -3)	*$24.3 million*	*$24.3 million*	--

The grant amendment also enables the Coalition to utilize unspent Year 3 funds (totaling $5.7 million) in the proposed Year 4 budget (to total no more than $15.7 million) should a Project Year workplan and Line-item budget be approved by CalOptima Health that supports the increased amount. Year 5 budget expenditures may be up to $10.0 million. Altogether, the budgeted expenditures will total no more than $50.0 million, or the total of the original grant agreement.

Grant Year/ Period	Revised Payment Schedule (Up to amounts)	Grant Amendment Provisions
Yr 4 (7/1/25 – 6/30/26)	$15.7 million	Payments are conditional upon receipt of the following items: • Acceptable annual progress and budget report • Project Year work plan • Line-item budget
Yr 5 (7/1/26 – 6/30/27)	$10.0 million	
Subtotal (Years 4-5)	*$25.7 million*	
Total (Years 1-5)	**$50.0 million**	

Back to Agenda

The grant amendment also includes provisions that Year 4 and Year 5 grant funding must not be expended until a Project Year work plan and a line-item budget have been received and approved by CalOptima Health.

Staff requests the Board ratify the grant amendment executed by the CEO to update terms and conditions related to payment, reporting and other contract provisions.

Fiscal Impact
The recommended action has no additional fiscal impact. A previous Board action on April 7, 2022, appropriated and authorized up to $50 million from existing reserves to fund the grant agreement with the Coalition of Orange County Community Health Centers.

Rationale for Recommendation
This action has been reviewed by the Grant Management Ad Hoc Committee of the Board. The recommended action aligns with CalOptima Health's obligations for appropriate management of contracts.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
April 7, 2022	Authorize Appropriation of Funds, Unbudgeted Expenditures and a Grant Agreement with the Coalition of Orange County Community Health Centers for Population Health and Value-Based Care Transformation	-	$50,000,000

/s/ Michael Hunn *07/31/2025*
Authorized Signature **Date**

Back to Agenda

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Coalition of Orange County Community Health Centers	600 W. City Parkway West	Orange	CA	92868

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 7, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

18. Ratify Amendments to the Grant Agreements with CalOptima Health Comprehensive Community Cancer Screening and Support Grantees

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, (714) 954-2140

Recommended Actions

Ratify the amendments to grant agreements with the first round of community grants recipients in the CalOptima Health Comprehensive Community Cancer Screening and Support Program approved on August 1, 2024, that included the following:

1. Insert additional measurable objectives that align with the original scopes of work to ensure consistent monitoring across grantees;
2. Provide a no-cost extension to provide grantees additional time to execute the program;
3. Realign the reporting requirements with the calendar year to provide consistency when evaluating Healthcare Effectiveness Data and Information Set measures and screening rates;
4. Remove the line item budgets from the grant agreement and instead include terms for managing the budget outside of the agreement; and
5. Change the pay schedule to more closely align with the reporting schedule, ensuring grantees are paid on a timely basis and coinciding with demonstration of positive performance against metrics.

Background

In December 2022, the CalOptima Health Board (Board) approved the Comprehensive Community Cancer Screening and Support Program (Program) with a reallocation from Intergovernmental Transfer (IGT) 9 funds and an allocation from IGT 10 funds not to exceed $50.1 million, in aggregate, over five years. The goals of the Program are to decrease late-stage cancer diagnosis rates, increase early detection through improved awareness and access to cancer screening, and improve quality and member experience during cancer screening and treatment among Medi-Cal members for breast, cervical, colon, and lung cancer (in certain smokers).

In February 2024, based on stakeholder input, data analysis, and a review of research and best practices, CalOptima Health staff proposed, and the Board approved, five Program initiatives: (i) Community Grants, (ii) Orange County Cancer Screening and Support Collaborative, (iii) Vendor Contracts to Support the Member Journey, (iv) Program Research and Evaluation, and (v) Internal Program Support.

Under the Community Grants Program initiative, the Board approved up to $30 million across two rounds of competitive grants. Following Board approval, CalOptima Health staff developed and released the first notice of funding opportunity (NOFO) to support screening activities, which allowed for costs for capacity building, infrastructure and capital improvements, and care coordination to increase screening and decrease late-stage discovery.

Back to Agenda

In August 2024, the Board approved 15 Community Grants totaling $16,417,044. The grant agreements were executed in September 2024, and grantees have been performing work toward their stated goals since that time. Please see Attachment 2 for the list of grantees.

Discussion

CalOptima Health staff has been providing oversight of the grants in accordance with CalOptima Health Policy AA.1400: Grant Management and committed to providing updates to the Board on the status of these grants at future meetings. After six months of significant effort toward the Program initiatives, CalOptima Health staff has identified some challenges to grantee success that can be remedied through tweaks to the Program design documented through a grant amendment.

Timeline Considerations: Several of the grantees saw a slight delay during implementation in launching their ambitious two-year plans. Further, the reporting schedule needs to be re-aligned with calendar year reporting to ensure consistent data collection, especially given the focus on Healthcare Effectiveness Data and Information Set measures and the rate and timing at which those measures are available. As a result, staff propose to:

- Extend the grant period by six months, anticipating the need for no-cost extensions, but also giving grantees time to achieve their goals, stay connected throughout the process, and align with calendar year reporting timeframes.

Budget Considerations: Interconnected to timeline considerations are challenges with expending large grant awards within a short spend window. Spending was slow to begin, with organizations on average only expending 30% of their year one budget in the first six months (as opposed to 50%). The proposed six-month extension will support the grantees' ability to spend out before the end of the grant period. Other budget recommendations include:

- An optional opportunity for grantees to revise their budgets to reflect a 30-month timeline, and
- Adjustment to the payment schedule so that CalOptima Health is not paying grantees in arrears and has a greater opportunity to control payments based on performance.

Metrics Considerations: While all grantees have measurable objectives related to their performance, they are varied in nature. To bring consistency in reporting and to generate a consistent message of return on investment, staff recommends that:

- Grant agreements be revised to include uniform volume of referrals and/or screenings achieved objectives that connect to each reporting period so that a consistent metric can be used to gauge progress.

To address these needed changes, CalOptima Health worked with legal counsel to draft a template grant amendment (Attachment 1) that addresses the above recommended changes. CalOptima Health staff worked with grantees (Attachment 2) to execute amendments to their agreements using this template, accounting for slight variation across funded programs. CalOptima Health staff is requesting the Board of Directors now ratify the amendments.

Furthermore, staff will continue to provide oversight of the grants in accordance with CalOptima Health Policy AA.1400: Grant Management and will return to the Board to provide updates on the status of these grants at future meetings.

Back to Agenda

Fiscal Impact
The recommended action has no additional fiscal impact. The Board authorized $15.0 million on February 1, 2024, and allocated $1,417,044 on August 1, 2024, to fund the first round of community grants totaling $16,417,044.

Rationale for Recommendation
This recommended action has been reviewed with the grant management ad hoc committee of the Board. CalOptima Health is committed to improving cancer screening rates, health outcomes, and member experience. Approving this amendment will support grantees in continuing to work on improvement of cancer screenings, early cancer diagnosis, and treatment for CalOptima Health members. Staff will bring additional updates and recommendations to the Board for review and approval in the future.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Grant Amendment Template
2. Entities Covered by this Recommended Action

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 1, 2022	Authorize Actions Related to the CalOptima Health Comprehensive Community Cancer Screening and Support Program for Medi-Cal Members	5 Years	$50.1 million
February 1, 2024	Approve the CalOptima Health Comprehensive Community Cancer Screening and Support Program Initiatives and Actions to Develop and Release a Notice of Funding Opportunity	2 Years	$15 million (from the previously Board-allocated $50.1 million)
August 1, 2024	Approve the CalOptima Health Comprehensive Community Cancer Screening and Support Grantees	2 Years	$16,417,044

/s/ Michael Hunn *07/31/2025*
Authorized Signature **Date**

Back to Agenda

AMENDMENT NO. 1 TO
GRANT AWARD AGREEMENT

This Amendment No. 1 to the Grant Award Agreement ("**Amendment**") by and between Orange County Health Authority, a public agency dba CalOptima Health, ("**CalOptima**") and [insert Grantee name] ("**Grantee**") is effective June X, 2025 ("**Amendment Effective Date**"). CalOptima and Grantee may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and Grantee entered into the Grant Award Agreement, originally effective September 1, 2024, ("**Agreement**") under which CalOptima designated certain Intergovernmental Transfer ("**IGT**") funds for the Grant Award to Grantee to support cancer screening activities for CalOptima members.

B. CalOptima and Grantee desire to amend the Agreement on the terms and conditions set forth herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Delete Section 1.3, *Unauthorized Use of Funds*, of the Agreement in its entirety and replace it with the following new Section 1.3, *Unauthorized Use of Funds*:

   1.3 **Unauthorized Use of Funds**. Grantee shall use Grant Funds in accordance with this Agreement, applicable laws, and the approved Grant Activities. CalOptima retains the right to recover any and all Grant Award funds if it (or any of its regulators) determines (i) that any portion of the Grant Award was not expended as provided under the terms of this Agreement or (ii) Grantee did not comply with the Agreement or applicable federal and state laws, regulations, guidance and/or funding source requirements.

2. Add the following Section 3.4, *Conflicts of Interest*, to the Agreement:

   3.4 **Conflicts of Interest**. No director, officer, employee, or agent of Grantee may obtain a financial interest or benefit from the Grant Project, including any subcontracts, during their tenure with Grantee and for one (1) year thereafter. Grantee also represents and warrants that it does not have an existing financial or business relationship with any director, officer, or employee of CalOptima. Grantee and its members, officers, employees, agents, designees, and subcontractors will comply with all applicable laws and CalOptima policies regarding conflicts of interest, and Grantee shall incorporate, or cause to be incorporated, in all subcontracts relating to the Grant Project a provision that includes the requirements of this section. Grantee will immediately notify CalOptima of any violation of this Section 3.4

3. Delete Section 4.3, *Audit*, of the Agreement in its entirety and replace it with the following new Section 4.3, *Monitoring*:

   4.3 **Monitoring**. CalOptima shall have the right to perform Grant Program and fiscal monitoring of Grantee to ensure compliance with federal and state requirements and the terms of this Agreement, including auditing, or having audited by an independent third party, Grantee regarding the Grant Project, Grant Award, and related expenses. Grantee shall fully cooperate with CalOptima's monitoring under this section, including any CalOptima auditor. Grantee must resolve any monitoring findings to CalOptima's satisfaction by the deadlines set by CalOptima and refund to CalOptima any amounts found to have been improperly expended from the Grant Award within thirty (30) days of the notice of such improper expenditures. Grantee shall be entitled to challenge any audit finding through appealing through

Back to Agenda Back to Item

CalOptima's grievance process.

4. Delete Section 5.9, *Termination*, of the Agreement in its entirety and replace it with the following new Section 5.9, *Termination*:

5.9 **Termination**. Sections 5.7 and 5.8 shall survive the termination of this Agreement.

5. Delete Section 6.1, *Term of Agreement*, of the Agreement in its entirety and replace it with the following new Section 6.1, *Term of Agreement*:

6.1 **Term of Agreement**. This Agreement will commence on the Effective Date and will remain in effect up to and including February 28, 2027, or completion of the Grant Project, whichever occurs first ("**Termination Date**"). CalOptima Health, in its sole discretion, may extend the term of the Agreement where the Grantee has not completed the Grant Project by the Termination Date. Grantee must request such an extension in writing, setting forth good cause for the request, prior to the Termination Date. If CalOptima Health opts to grant the term extension, it shall set forth the terms and conditions of the extension in writing, including the duration of the extension and reporting requirements during the extension. If Grantee does not accept those terms and conditions, the Agreement will terminate on the Termination Date.

6. Add the following Section 7.20, *Dispute Resolution*, to the Agreement:

7.20 **Dispute Resolution**.

7.20.1 Meet and Confer. If either Party has a dispute arising under or related to this Agreement, the Parties shall informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 7.20.2.

7.20.2 Arbitration. Subject to the California Government Claims Act (Cal. Gov. Code §900 *et seq*.) governing claims against public entities, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Agreement shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making

Back to Agenda Back to Item

decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

7.20.3 Exclusive Remedy. With the exception of any dispute that under applicable laws may not be settled through arbitration, arbitration under Section 7.20.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Agreement that is not resolved through the meet-and-confer processes.

7.20.4 Waiver. By agreeing to binding arbitration as set forth in Section 7.20.2, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

7. Add the following Section 7.21, *Survival*, to the Agreement:

7.21 **Survival**. The following provisions of this Agreement shall survive termination or expiration of this Agreement: Sections 1.3 (Unauthorized Use of Funds), 1.6 (Communications Provisions), 3.3 (Confidentiality of Information), 4.1 (Maintain Complete Books and Records), 4.3 (Monitoring), 5.7 (Indemnification), 7.1 (Interpretation of Agreement Language), 7.2 (Waiver), 7.4 (Independent Parties), 7.7 (Invalidity or Unenforceability), 7.9 (No Waiver of Immunity or Privilege), 7.10 (Choice of Law), 7.12 (Interpretation), 7.20 (Dispute Resolution), and any other Agreement provisions that by their nature are intended to survive termination or expiration of this Agreement.

8. Delete in its entirety the Grant Project Budget table from Section 1 to Attachment A, *Grant Project*, of the Agreement.

9. Add the following Section 2 to Attachment A, *Grant Project*, of the Agreement:

[add a set of time-based measurable objectives based on their proposed goals and implementation plan].

10. Delete Attachment B, *Grant Payment,* of the Agreement in its entirety and replace it with a new Attachment B, *Grant Payment,* which is attached to this Amendment and incorporated into the Agreement by this reference.

11. Delete Attachment C, *Progress Report Schedule,* of the Agreement in its entirety and replace it with a new Attachment C, *Progress Report Schedule,* which is attached to this Amendment and incorporated into the Agreement by this reference.

12. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Agreement.

13. If there is any conflict or inconsistency between this Amendment and the Agreement, the provisions of this Amendment shall control and govern. Except as otherwise amended by this Amendment, all of the terms and conditions of the Agreement will remain in full force and effect. After the Amendment Effective Date, any reference to the Agreement shall mean the Agreement as amended and supplemented by this Amendment.

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR GRANTEE:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

ATTACHMENT B
Grant Payment

CalOptima has made a Grant Award to Grantee in the amount of one million, eighteen thousand, six hundred dollars ($1,018,600) ("**Grant Award Amount**"), which is the maximum amount payable for the Grant Project and shall be paid following execution of the Agreement in the time and manner set forth below.

1. Payments: Payments under this Agreement shall be made in four (4) installments. The first payment shall be made upon execution of this Agreement, with subsequent payments made in accordance with Section 2 below.

   All payments following the initial Grant Award payment are contingent upon (i) CalOptima's receipt and approval of progress reports and/or final report and Grantee's annual line item budget for the Grant Project, and (ii) Grantee's attendance at quarterly Grant Project meetings, which are due as condition of that payment. Such reports and budgets must be acceptable to CalOptima and demonstrate progress toward Grant Project over the timeline, as provided in Section 4.2 and 4.3 of the Agreement. CalOptima may delay or withhold Grant Award payments at its sole discretion if such reports and/or budgets are not submitted timely or as otherwise required or if CalOptima is not satisfied with any submitted reports/budgets and/or Grantee's progress on Grant Project objectives.

   If Grantee's actual Grant Award expenditures are expected to vary by more than ten percent (10%) ("**Variation Threshold**") from any CalOptima-approved line item budget entry, Grantee must obtain prior written approval from CalOptima before spending any amount of the Grant Award in excess of the Variation Threshold. Failure to obtain CalOptima's prior written approval for expenditures in excess of the Variation Threshold shall constitute a breach of the Agreement and entitle CalOptima to recoup some or all of the Grant Award, in its sole discretion.

   In addition, CalOptima shall only issue Grant Award payments #2 through #4 below after Grantee has timely completed its Grant Project objectives to date, met all its reporting obligations under the Agreement, and spent a minimum of eighty percent (80%) of the Grant Award previously received from CalOptima under this Agreement. CalOptima may withhold or reduce Grant Award payments, in its sole discretion, if Grantee has not spent a minimum of eighty percent (80%) of the Grant Award previously received from CalOptima in accordance with the Agreement requirements, including the Grant Project description in Attachment A.

2. Payment Schedule:

   - Payment #1: **25% of the Grant Award Amount** *(conditional upon receipt of signed grant agreement)*
   - Payment #2: **35% of the Grant Award Amount** *(conditional upon acceptable annual progress report #3 and line item budget and proof of at least 80% spend of Payment #1)*
   - Payment #3: **20% of the Grant Award Amount** *(conditional upon acceptable annual progress report #4 and line item budget and proof of at least 80% spend of Payment #1 and #2)*
   - Payment #4: **20% of the Grant Award Amount** *(conditional upon acceptable annual progress report #5 and line item budget and proof of at least 80% spend of Payment #1, #2, and #3)*

3. Return Funds: Grantee shall refund to CalOptima any funds that are found to not have been utilized in accordance with this Agreement's requirements. CalOptima shall have the right to audit, or to have audited by an independent third party, all Grant Project expenses. Grantee shall fully cooperate with CalOptima or its auditor and shall refund to CalOptima any amounts found to have been improperly expended from the Grant Award within thirty (30) days of the notice of such improper expenditures.

ATTACHMENT C
Progress Report Schedule

Purpose of Grant Reports

To help ensure successful grant outcomes, CalOptima actively monitors and evaluates grant progress and requires that grantees submit semi-annual progress reports as well as a final report. These reports are intended to help both CalOptima and grantee appraise progress toward funding objectives.

Grant Report Requirements

All grant recipients must complete the Grant Report Form provided through written communication with CalOptima's Strategic Development department. Please note that successful completion of reports is a condition of Grant Award funding and incomplete reports will delay the disbursement of future Grant Award payments.

Report Submission Schedule

Report Submission Schedule

This grant requires the submission of six (6) reports over the duration of the project timeframe as follows:

- **Quarterly Progress Reports** will be due within thirty (30) calendar days after the end of each reporting period.
    - Specific due dates and Reporting Periods Covered:
        - Quarterly Progress Report #1: Due by December 31, 2024, for reporting period September 1, 2024, to November 30, 2024
        - Quarterly Progress Report #2: Due by March 30, 2025, for reporting period December 1, 2024, to February 28, 2025

- **Semi-Annual Progress Reports** will be due within thirty (30) calendar days after the end of each reporting period.
    - Specific due dates and Reporting Periods Covered:
        - Progress Report #3: Due by July 30, 2025, for reporting period January 1, 2025 – June 30, 2025.
        - Progress Report #4: Due by January 30, 2026, for reporting period July 1, 2025 – December 31, 2025.
        - Progress Report #5: Due by July 30, 2026, for reporting period January 1, 2026 – June 30, 2026.

- **Final Report** will be due within thirty (30) calendar days after the completion of the Grant Project.
    - Specific due date and Reporting Period Covered:
        - Final Report: Due by February 28, 2027, for reporting period September 1, 2024, to January 30, 2026.

- **Quarterly Meetings** will be held by CalOptima Health to facilitate relationship building among grantees and foster opportunities for collaboration. Grantees are expected to participate in the quarterly meetings, which may be held in-person or virtually. If Grantee is unable to attend a quarterly meeting due to unavoidable or unforeseen circumstances, they are expected to schedule

and participate in a makeup meeting with CalOptima Health staff.

CalOptima may require additional reporting from the Grantee during the term of the Agreement, as CalOptima determines in its sole discretion.

Attachment to the August 7, 2025, Board of Directors Meeting – Agenda Item 18

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Ave.	Commerce	CA	90040
American Cancer Society, Inc.	270 Peachtree Street, Suite 1300	Atlanta	GA	30303
Celebrating Life Community Health Center	27800 Medical Center Road, Suite 110	Mission Viejo	CA	92691
Families Together of Orange County	661 W. 1st Street	Tustin	CA	92780
Friends of Family Health Center	501 S Idaho St	La Habra	CA	90631
Hurtt Family Health Clinic	14642 Newport Ave, Suite 300	Tustin	CA	92780
Korean Community Services	451 W Lincoln Ave.	Anaheim	CA	92805
Laguna Beach Community Health Center	362 Third Street	Laguna Beach	CA	92656
Latino Health Access	405 W. 4th Street	Santa Ana	CA	92701
mPulse	21255 Burbank Blvd	Los Angeles	CA	91369
Share Ourselves	20151 SW Birch Street, Suite 100	Newport Beach	CA	92660
The G.R.E.E.N Foundation	2030 E. Fourth Street, Suite D213	Santa Ana	CA	92705
UCI Family Health Center	800 N. Main Street	Santa Ana	CA	92701

Back to Agenda Back to Item

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 7, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item
19. Ratify Extension of Grant Award Agreement with Mind OC for the Be Well OC Irvine Campus

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Kelly Bruno-Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741

Recommended Action
Ratify the grant amendment that extends the term of the grant award agreement with Mind OC for the Be Well OC Irvine campus through December 31, 2025.

Background and Discussion
On August 4, 2022, the CalOptima Health Board of Directors (Board) authorized the Chief Executive Officer (CEO) to execute a grant agreement with Mind OC to improve quality and access to enhanced and integrated behavioral health services for CalOptima Health members at the Be Well Wellness Hub in the City of Irvine (Be Well OC Irvine). The Board also appropriated up to $15 million from reserves to fund the grant agreement with Mind OC.

CalOptima Health and Mind OC entered into a grant agreement on December 1, 2022, under which CalOptima Health provided $15 million to Mind OC to help fund the Be Well OC Irvine campus. The agreement was amended effective October 31, 2024, and is set to terminate on July 31, 2025, or upon completion of the project, whichever occurs first.

To date, CalOptima Health has released $14.2 million to Mind OC for the grant and has $771,135 remaining in the escrow account.

Based on progress reports from Mind OC, completion of this construction project was delayed due to project dependencies, including establishment of a main electrical connection and main storm drain line connection. Final certificate of occupancy of the Phase 1 development will be dependent on completion of these activities. Once these connections are established, further construction activities can continue. The project is now tentatively scheduled to be complete in the fall of 2025. Mind OC has provided the following remediation plan to meet the revised completion date:

- Closely monitor and work through construction logistics with all parties.
    - County Real Estate Office, Southern California Edison, and the Department of Navy to coordinate on finalizing the easement documentation and securing resources for the final site connection.
    - City of Irvine, FivePoint, County of Orange, and Second Harvest, to ensure coordination of the effort.
- Ongoing communication with CalOptima Health through meetings and site visits to discuss progress and status updates of activities and efforts to resolve delays.
- Continue construction efforts for other planned installation activities surrounding interior and exterior details.

Back to Agenda

Based on the above plan, staff requests the Board ratify the grant amendment executed by the CEO to extend the term of the grant to December 31, 2025. In the event Mind OC is unable to complete the grant commitments by December 31, 2025, CalOptima Health retains the ability to recoup funds not spent toward the grant objectives.

Fiscal Impact
The recommended action to extend the term of the grant agreement to December 31, 2025, has no additional fiscal impact.

Rationale for Recommendation
This action has been reviewed by the Grant Management Ad Hoc Committee of the Board. The recommended action aligns with CalOptima Health's obligations for appropriate management of contracts.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action

/s/ Michael Hunn *07/31/2025*
Authorized Signature **Date**

Back to Agenda

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MindOC	18650 MacArthur Blvd., Ste 350	Irvine	CA	92612