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

JUNE 5, 2025
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

TELECONFERENCE LOCATION:
ASSOCIATION OF CALIFORNIA WATER AGENCIES
980 9TH STREET. SUITE 1000
SACRAMENTO, CA 95814

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	OUTSIDE GENERAL COUNSEL	CLERK OF THE BOARD
Michael Hunn	James Novello Kennaday Leavitt	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_ISq0ctO1TrCTUeR5m9-x7Q** to Join the Meeting.
Webinar ID: **885 1230 4649**
Passcode: **989778** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS
1. Chief Executive Officer Report

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

CONSENT CALENDAR
2. Minutes
   a. Approve Minutes of the 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 Service

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

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 Filing

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

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

REPORTS/DISCUSSION ITEMS

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

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

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

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

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

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

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

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

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

29. Approve Actions Related to the Housing and Homelessness Incentive Program

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

31. Authorize Extension of Grant Award Agreement with Mind OC for the Be Well OC Irvine Campus

32. Approve Actions Related to Contracts for Legal Services

33. Authorize Unbudgeted Expenditures and Appropriate Funds for Legal Services

CLOSED SESSION

CS-1. Pursuant to Government Code section 54956.87, subdivision (b) HEALTH PLAN TRADE SECRETS: Covered California

CS-2. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Government Code section 54956.9(d)(2): 3 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 June 5, 2025 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_ISq0ctO1TrCTUeR5m9-x7Q

To **Join** this webinar:
https://us06web.zoom.us/s/88512304649?pwd=LS1dya2xlbPEOmu51uJtul9Ik70x8X.1

Phone one-tap:
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+12532158782,,88512304649#,,,,*989778# US (Tacoma)

Join via audio:
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+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
+1 305 224 1968 US
+1 309 205 3325 US
+1 312 626 6799 US (Chicago)
+1 360 209 5623 US
+1 386 347 5053 US
+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
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Webinar ID: 885 1230 4649
Passcode: 989778
International numbers available: **https://us06web.zoom.us/u/kb0K0tIxXs**

CalOptima Health

MEMORANDUM

DATE:	May 29, 2025
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — June 5, 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 launching a Covered California line of business, effective January 1, 2027. Since the prior Board meeting on May 1, the following activities were undertaken:

- Provider network development continues with many provider contracts already executed or in negotiations.
- Following onboarding by staff, Deloitte Consulting LLP began its operational gap analysis to guide the implementation of Covered California processes across all impacted departments.
- Several new and revised policies and procedures documents were drafted to comply with Knox-Keene Act and Covered California requirements. The Board will consider the new policies on June 5, 2025, ahead of a planned material modification filing to expand CalOptima Health's current Knox-Keene Act license with the California Department of Managed Health Care.
- Fiscal Year (FY) 2025–26 start-up costs for implementation of Covered California functions were included as part of CalOptima Health's full budget package prepared for the Board's consideration on June 5, 2025.

B. U.S. House of Representatives Passes Budget Reconciliation Legislation

On May 22, the U.S. House of Representatives passed its FY 2025 budget reconciliation legislation — now titled *H.R.1: One Big Beautiful Bill Act* — by a near-party-line vote of 215–214. Among Orange County's House delegation, the one Republican representative, Young Kim, voted Yes, and all five Democratic representatives voted No. H.R. 1 proposes significant Medicaid funding reductions and policy changes with potential impacts to CalOptima Health, 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
- Increased frequency of eligibility redeterminations for Medicaid Expansion (MCE) enrollees from annually to every six months, effective December 31, 2026
- State penalty for coverage of undocumented immigrants by decreasing the Federal Medical Assistance Percentage (FMAP) for MCE enrollees from 90% to 80%, effective October 1, 2027

- Cost-sharing for MCE enrollees with incomes of 100%–138% Federal Poverty Level, 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 made permanent by Proposition 35 in 2024, with a potential winddown period of up to three fiscal years

Next, the U.S. Senate will start consideration of H.R. 1 and is expected to incorporate amendments to reduce the severity of Medicaid cuts, but there is no indication of any specific changes at this time. To that end, CalOptima Health will increase engagement with key Senate staff in the coming weeks to share our concerns with the current provisions. Congressional leadership aims to pass final, agreed-upon legislation to President Donald Trump by July 4.

C. Governor Newsom Releases May Revision Budget Proposal

On May 14, Governor Gavin Newsom released his FY 2025–26 revised state budget proposal, also known as the May Revision, which totals $322 billion and addresses a projected $12 billion shortfall with significant reductions to ongoing programs. In particular, the May Revision highlights that Medi-Cal expenditures have increased substantially and are anticipated to keep growing through FY 2025–26, due in part to higher-than-expected Medi-Cal enrollment and increased pharmaceutical costs. Proposed solutions to address Medi-Cal cost growth issues are highlighted below due to significant potential impacts on CalOptima Health. As the State Legislature reviews the May Revision, CalOptima Health's staff, lobbyists and associations are engaging our state delegation and other key legislators to express concerns regarding several proposals. Next, the Legislature is expected to introduce a budget counterproposal before negotiating with the governor and passing a final budget by June 15.

Key Proposals:

- Modify Medi-Cal eligibility and benefits for undocumented members (i.e., those with Unsatisfactory Immigration Status [UIS]):
  - Prohibit the new enrollment of UIS adults ages 19 years and older
  - Impose $100 premiums on currently enrolled UIS adults ages 19 years and older
  - Eliminate dental benefits for currently enrolled UIS adults ages 19 years and older
  - Eliminate long-term care benefits for UIS individuals of all ages
  - Eliminate Prospective Payment System rates to community clinics for state-only-funded services to UIS individuals of all ages
- Eliminate the following Medi-Cal benefits:
  - Acupuncture
  - Anti-obesity medications (i.e., GLP-1s)
  - Some over-the-counter drug benefits, including COVID-19 tests and vitamins
- Cap Program of All-Inclusive Care for the Elderly (PACE) rates at the midpoint of the actuarial rate ranges, resulting in a ~2.8% rate cut ($1.1 million) to CalOptima Health PACE
- Impose an additional 1% administrative tax on PACE organizations
- Sweep some Proposition 35 funding to the General Fund to address existing Medi-Cal costs, leaving reduced funding for future Medi-Cal provider rate increases as originally intended
- Increase the minimum Medical Loss Ratio (MLR) requirement for Medi-Cal plans from 85% to 90%, with modifications to the MLR methodology
- Reinstate the Medi-Cal asset limit of $2,000 per individual ($3,000 per couple) for Seniors and People with Disabilities
- Eliminate the Skilled Nursing Facility Workforce Quality Incentive Program

- Eliminate Proposition 56 supplemental payments to dental, family planning and women's health providers
- Continue funding for current and planned CalAIM initiatives, including Transitional Rent, Community Supports and Enhanced Care Management

D. Centers for Medicare & Medicaid Services Proposes MCO Tax Restrictions

The U.S. Centers for Medicare & Medicaid Services (CMS) recently released a proposed rule that would significantly restrict states' use of MCO taxes and largely mirrors the related provision in the House-passed reconciliation legislation discussed above. In summary, the proposed rule would require uniformity between the MCO tax rates that are imposed on Medicaid and non-Medicaid lines of business. Depending on the final language, the current MCO tax structure could be terminated either immediately or one year after the enactment of the rule. CalOptima Health and our state trade associations are discussing the submission of public comments, which are due to CMS by July 14.

E. CalOptima Health Celebrates Cal State Fullerton's First Cohort of MSW Stipend Graduates

On May 21, CalOptima Health's first cohort of Master of Social Work stipend recipients graduated from Cal State Fullerton. Through our workforce development funding, these 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. We are proud that two students won the Outstanding Graduate Student Award, and another was honored with an Outstanding Research Award. This exemplary group is just the first group of sponsored graduates — the workforce program continues for four more years. A special thank you to Orange County Board of Supervisors Chairman and CalOptima Health Board Member Doug Chaffee for his work in championing this pilot program, which led to further provider workforce investments.

F. Mobile Mammogram Event Hosted at Northgate Market

CalOptima Health collaborated with Northgate Gonzalez Market and Alinea Medical Imaging to host a mobile mammogram event on May 30 at Northgate Market in Anaheim. The event provided access to care for CalOptima Health Community Network (CHCN) members while supporting our HEDIS and quality measures. A targeted text message was sent to members ages 50–74 who are due for a mammogram and live in the surrounding area. The event was also open to community members who are uninsured or underinsured, and their mammogram services were covered by the Every Woman Counts program. For completing a mammogram, CHCN members received a $25 Member Health Reward, and those who are uninsured or underinsured received a $25 Northgate gift card. This collaboration with Northgate Market provided an opportunity to increase our members' access to care while enhancing relationships with valued community stakeholders serving the Latino population, which represents nearly 44% of our total membership.

G. Chief Operating Officer Participates in OCBC Health Care Forum

Chief Operating Officer Yunkyung Kim participated in a panel at the Orange County Business Council's (OCBC) 2025 Health Care Forum on May 6. Joining local hospital and other industry leaders, Yunkyung highlighted CalOptima Health's focus on workforce development programs to ensure the long-term sustainability of Orange County's safety net health care system. She also emphasized the importance of our CalAIM investments in non-medical interventions, such as housing navigation services and medically tailored meals, to improve patient outcomes and reduce health care costs. Lastly, she discussed CalOptima Health's recent decision to participate in Covered California, starting in 2027, to ensure continuity of care for our members churning on and off Medi-Cal.

H. Street Medicine Program Celebrates Two-Year Anniversary

CalOptima Health's Street Medicine Program recently marked its two-year anniversary, celebrating success in delivering health care directly to our community's most vulnerable members. Since launch, the program has helped more than 600 individuals with primary care and social services, demonstrating our commitment to providing accessible health care. The most recent video in our member stories series features CalOptima Health member Matt Hurst, who shares his journey to housing after more than 10 years on the streets. Matt's inspiring story shares how our Street Medicine Program provided crucial support.

I. CalOptima Health Conducts OneCare Focus Groups

RSE, CalOptima Health's advertising agency for OneCare, conducted focus group research on our behalf to ensure the effectiveness of our campaign (started in October 2024) to promote OneCare as a unique Medicare + Medi-Cal plan offering in Orange County. The research engaged nine groups:

- English-speaking members, nonmembers and caregivers
- Spanish-speaking members, nonmembers and bilingual caregivers
- Vietnamese-speaking members, nonmembers and bilingual caregivers

The objectives of the mid-campaign research are to:

- Gauge changes in perceptions and awareness of CalOptima Health OneCare vs. pre-campaign
- Better understand the caregiver/influencer audiences
- Identify motivations, barriers and challenges for caregivers
- Test existing campaign creative and new caregiver concepts to determine possible optimizations

J. Communications Team Wins More Than 50 Awards for Advertising, Other Material

CalOptima Health's Communications team creates a wide variety of branded materials internally and directs advertising campaign development in collaboration with outside agencies. Recognition for this work hit an all-time high in May, winning 25 awards at the 42nd Annual Healthcare Advertising Awards, 26 awards at the Health Care Communicators of Southern California Finest Awards and four awards from the Telly Awards. Honored for creativity, impact and design, the winning advertising submissions were from our cancer screening awareness, PACE and OneCare campaigns, and included multimedia assets ranging from TV and digital ads to direct mail and print ads. Among the internal projects recognized were our 2025 Report to the Community, Street Medicine and Workforce Development News Releases, Provider Press Newsletter, Medi-Cal Expansion Campaign, Back-to-School Health and Wellness Fair, and more.

K. CalOptima Health Gains Media Coverage

On May 19, KFF Health News ran an article, "Housing, Nutrition in Peril as Trump Pulls Back Medicaid Social Services" that included a quote from Kelly Bruno-Nelson, DSW, CalOptima Health's Executive Director of Medi-Cal/CalAIM: "We believe wholeheartedly that housing is health, food is health, so seeing these programs disappear would be devastating." Since its publication, the article has been widely syndicated.

CalOptima Health

Fast Facts
June 2025

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

Membership Data* (as of April 30, 2025)

Total CalOptima Health Membership

901,899

Program	Members
Medi-Cal	884,054
OneCare (HMO D-SNP)	17,339
Program of All-Inclusive Care for the Elderly (PACE)	506

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

Key Financial Indicators (for 10 months ended April 30, 2025)

	Dashboard	YTD Actual	Actual vs. Budget ($)	Actual vs. Budget (%)
Operating Income/(Loss)	●	$119.3M	$339.5M	154.2%
Non-Operating Income/(Loss)	●	$160.3M	$106.5M	198.0%
Bottom Line (Change in Net Assets)	●	$279.6M	$446.0M	268.1%
Medical Loss Ratio (MLR) *(Percent of every dollar spent on member care)*	●	92.3%	---	(7.0%)
Administrative Loss Ratio (ALR) *(Percent of every dollar spent on overhead costs)*	●	4.9%	---	2.0%

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 88%.

Reserve Summary (as of April 30, 2025)

	Amount (in millions)
Board Designated Reserves*	$1,574.5
Statutory Designated Reserves	$131.6
Capital Assets (Net of depreciation)	$100.3
Unspent Balance of Allocated Resources	$437.6
Unspent Balance of Board Approved Provider Rate Increase**	$350.8
Unallocated Resources*	$130.0
Total Net Assets	$2,724.7

* Total of Board-designated reserves and unallocated resources can support approximately 157 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 Annual Budgeted Revenue **$4 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

June 2025

Personnel Summary (as of May 17, 2025, pay period)

	Filled	Open	Vacancy % Medical	Vacancy % Administrative	Vacancy % Combined
Staff	1,339.25	35.15	50.95%	49.05%	2.56%
Supervisor	85	2	0%	100%	2.3%
Manager	118	9	11.11%	88.89%	7.09%
Director	69	8	25%	75%	10.39%
Executive	22	0	---%	---%	---%
Total FTE Count	1,632.3	55.2	47.89%	52.11%	3.27%

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

Provider Network Data (as of May 20, 2025)

	Number of Providers
Primary Care Providers	1,312
Specialists	7,340
Pharmacies	606
Acute and Rehab Hospitals	41
Community Health Centers	65
Long-Term Care Facilities	206

Treatment Authorizations (as of March 31, 2025)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	33.66 hours
Prior Authorization – Urgent	72 hours	21.9 hours
Prior Authorization – Routine	5 days	3.25 days

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

Member Demographics (as of April 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%

Covered CA: Department of Managed Health Care (DMHC) Licensure Process

Board of Directors Meeting
June 5, 2025

Donna Laverdiere
Executive Director, Strategic Development

Our Mission

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

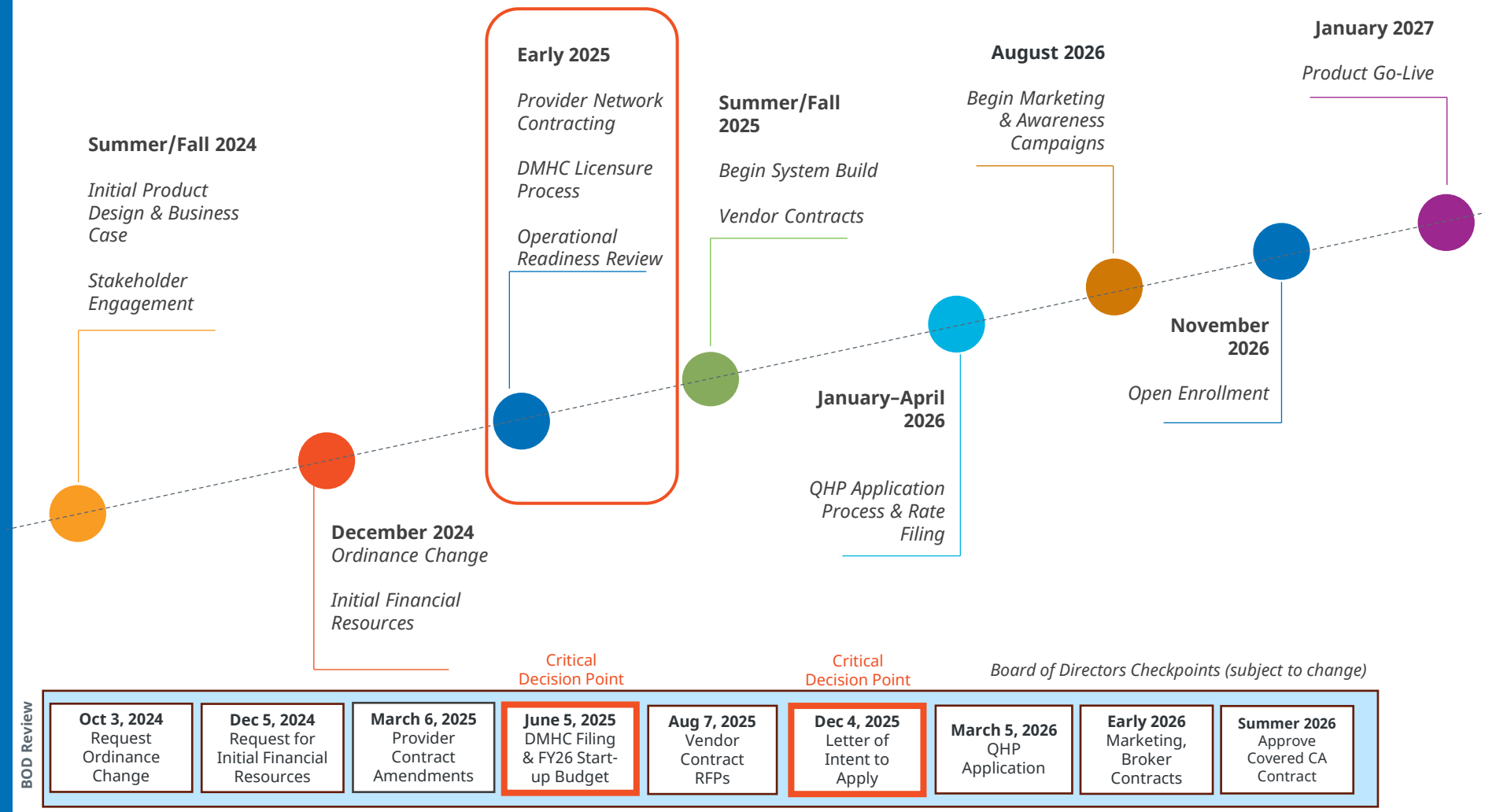
Our Vision

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.

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BOARD

Covered CA — High-Level Implementation Timeline



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Previous Covered CA Board Actions

Date	Item
August 1, 2024	• Stakeholder Engagement and Convening of a Steering Committee
October 3, 2024	• Guiding Principles and Ordinance Change Request
December 5, 2024	• Consulting Support Budget
March 6, 2025	• Provider Network Contract Templates
May 1, 2025	• Operational Implementation Support & Project Management Consultant Contract • Provider Network Design and Benefit Vendor Contracts

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DMHC Licensure Process

- CalOptima Health must expand the scope of our current Knox-Keene Act license to operate a Covered CA product
- The CA Department of Managed Health Care (DMHC) process includes the submission of a filing including up to 89 required exhibits
- Required exhibits will be submitted to DMHC in multiple rounds:
  - Initial Filing: **June 2025**
  - Second Submission: October 2025
  - Third Submission: February 2026

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Requested Board Actions – June 2025
DMHC Filing

- Under one Report Item, CalOptima Health staff is requesting approval to submit a filing to DMHC to expand the scope of our Knox-Keene Act license
  - ***Recommended Action:*** *Approve Actions Related to Knox-Keene Act Licensure Filing to the Department of Managed Health Care (DMHC) for Covered California Participation*
- The initial filing is planned for mid-June 2025
- The initial filing includes numerous exhibits that are outlined on the following slide

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Initial DMHC Filing Exhibits

Type of Exhibit	Description of Documentation
Organizational Documents	• Organizational charts, statements of key management duties and resumes
Legal Documents	• Narrative summaries describing plan organization and operations • Bylaws • Summary of any relevant criminal, civil and administrative proceedings • Demonstration of compliance with Knox-Keene Act requirements
Clinical Operations	• Policies related to coordination of care and referral processes • Utilization Management program description and committee structure
Core Operations	• Descriptions of provider claims payment processes • Policies related to language access, grievance procedures and grievance forms
Quality	• Quality of care review system • Policies describing quality assurance, provider credentialing/re-credentialing and timely access
Fraud, Waste and Abuse	• Fraud, Waste and Abuse plan
Provider Network	• Provider and facility rosters and ratios • Policies describing standards of accessibility, provider directory and provider oversight • Copies of provider contracts
Administrative Contracts	• List of contracts with affiliated persons, principal creditors and vendors • Templates and executed contracts for all vendors
Sales & Marketing	• Marketing statement/advertisements (to be filed in 2026)
Finance	• Enrollment and financial projections

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Requested Board Actions – June 2025
Policies and Procedures

- The Consent Calendar includes five items that encompass approval of 11 new Policies & Procedures that are required to be submitted to DMHC:
  - CalOptima Health **Clinical Policies** (4)
    - CC.1600: Authorization and Processing of Referrals
    - CC.1400: Behavioral Health Services
    - CC.1500: Continuity of Care for Members Transitioning into CalOptima Health Services
    - CC.1501: Continuity of Care during Health Network or Provider Termination
  - CalOptima Health **Operations Policies** (4)
    - CC.1200: Member Appeals
    - CC.1201: Member Grievances
    - CC.1001: Claims Processing for Covered Services
    - CC.1300: Block Transfer
  - CalOptima Health Policy CC.1100: **Oversight of Administrative Vendors**
  - CalOptima Health Policy CC.1700: **Standards of Accessibility and Timely Access**
  - CalOptima Health Policy CC.2000: **Emergency Declaration**

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Today's Covered CA Board Actions

Date	Item
June 5, 2025	**Consent Calendar Items (5)** 1. New Clinical Policies (4) 2. New Operations Policies (4) 3. New Policy CC.1100: Oversight of Administrative Vendors 4. New Policy CC.1700: Standards of Accessibility and Timely Access 5. New Policy CC.2000: Emergency Declaration **Report Item (1)** 6. Request to submit DMHC Licensure Filing

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Implementation Update

- Provider Network
  - The Board approved contract templates for participating Covered CA providers on March 6
  - Outreach to health networks and providers has begun
  - Actuaries supported the development of enrollment projections and reimbursement rate estimates
- Operational Readiness
  - Deloitte was selected as the consultant for Covered CA operational readiness and implementation support
  - An operational gap analysis has begun, and a detailed roadmap and work plan for implementation will be developed
- Covered CA Engagement
  - Staff met with Covered CA leadership to discuss our Qualified Health Plan (QHP) application approach and timeline

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CalOptima Health

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REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

May 1, 2025

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on May 1, 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 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. Vice Chair Vicente Sarmiento called the meeting to order at 2:01 p.m., and Supervisor Doug Chaffee led the Pledge of Allegiance.

ROLL CALL

Members Present: Supervisor Vicente Sarmiento, Vice Chair; Maura Byron; Supervisor Doug Chaffee; Blair Contratto; Norma García Guillén; Catherine Green, R.N.; Brian Helleland; Veronica Kelley (non-voting); Jose Mayorga, M.D.
(All Board members participated in person)

Members Absent: Isabel Becerra, Chair

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

Vice Chair Sarmiento noted that he would be running today's meeting in Chair Becerra's absence.

PRESENTATIONS/INTRODUCTIONS

1. Workforce Development Round Two Grantee Check Presentations

Carmen Katsarov, Executive Director, Behavioral Health Services, started off wishing everyone a happy Mental Health Awareness Month, noting that May 1 is the beginning of Mental Health Awareness. Ms. Katsarov also noted that for CalOptima Health, the Mental Health Awareness theme is the power of partnerships. She added that CalOptima Health is very proud of the work that is being done in support of its members and is very grateful to its Board and community partners to provide whole person care, which includes physical health, mental health and wellness, and social health. Ms. Katsarov shared that the shortage of behavioral health professionals is well documented in California, with the state lacking enough mental health and substance use providers to meet the continued rising demand for behavioral health services. In honor of Mental Health Awareness Month, CalOptima Health would like to highlight the workforce development round two grantees who received funding to help address critical behavioral health workforce shortages by providing workforce training, upskilling and employment pathways to health professionals who serve Medi-Cal members in Orange County. Ms. Katsarov turned the microphone over to Donna Laverdiere to introduce the workforce grantees.

Donna Laverdiere, Executive Director, Strategic Development, reported that in honor of Mental Health Awareness Month, CalOptima Health would like to recognize the grantees selected for the second round of Provider Workforce investments. These grantees were awarded a total of $5.1 million in grant funding to increase the behavioral health workforce as part of CalOptima Health's ongoing Provider Workforce Development Initiative.

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Ms. Laverdiere introduced the six grantees as follows:

Child Guidance Center, Inc., was awarded $766,920 to fund their Help the Helper - Strengthening Orange County's Behavioral Health Workforce Program, which will train 35 graduate students pursuing master's and doctoral degrees in mental health.

Children's Hospital of Orange County was awarded $994,824 to help fund their Pediatric Behavioral Health Field Training Expansion Program, which will train an additional 92-96 social work and psychology students over a four-year program period.

John Henry Foundation was awarded $847,302 to fund their Intern Psychologist Workforce Development Program, which will train 25 PhD and PsyD candidates over a five-year period with the skills to treat severe mental health conditions.

Seneca Family of Agencies was awarded $996,130 to fund a Behavioral Health Clinical Internship Program, which will train 18 master's level graduate students in mental health focused programs (master's degree in social work, master's degree in marriage & family therapy, master's degree in counseling psychology) over a three-year period.

Special Service for Groups, Inc., was awarded $535,566 to fund their Professional Providers Pathway (Px3) Program: A paid internship opportunity for 25 graduate students over a five-year period pursuing behavioral health degrees with a focus on service provision.

Western Youth Services was awarded $1,000,000 to fund their Western Youth Services Workforce Development Program, which will increase the supply of behavioral health professionals through financial incentives for student interns, behavioral health specialists, care managers, mental health workers, therapeutic behavioral coaches, and peer support specialists. The program will provide tuition reimbursement for 55 staff, licensure fee reimbursement for 80 staff, stipends for 35 master's level interns over a five-year period, and 380 continuing education units for staff.

Grantees were provided ceremonial checks and took photographs with the Board to celebrate the improved services that these grantees will be able to offer for CalOptima Health members.

MANAGEMENT REPORTS

2. Chief Executive Officer (CEO) Report

Yunkyung Kim, Chief Operating Officer, presented the CEO report and started by thanking all the mental health providers for their service in recognition of the Mental Health Awareness Month.

Ms. Kim reported that CalOptima Health had its exit conference with the Department of Health Care Services (DHCS) for its annual medical audit. She noted that the audit covered utilization management, care management, access and availability, member rights, quality improvement, and organizational capacity, with only four findings, for which corrective action plans have been submitted.

Ms. Kim congratulated Kennaday Leavitt, CalOptima Health's Outside General Counsel, for being featured in the 2025 Chambers USA Spotlight Guide. She noted that this is a tremendous distinction in the legal field.

Ms. Kim reviewed the Fast Facts, noting that CalOptima Health currently services just under 910,000

individuals. She also noted that Nancy Huang, Chief Financial Officer, will be walking the Board through enrollments and budget projections but wanted to bring to the Board's attention the change in the Fast Facts regarding the Board reserves. Ms. Kim noted that at its April 3, 2025, meeting the Board approved a change to CalOptima Health's reserve policy to increase the reserves from three months to up to four months of revenue.

Ms. Kim also provided an update on CalOptima Health's Covered California activities, noting that there are two actions on the agenda today, and several other actions will be brought to June Board meeting.

Ms. Kim thanked CalOptima Health's members, Board members, and stakeholders for their input and feedback on its newly redesigned website. She noted that staff believe it provides an easier way to access information and access services at CalOptima Health and encouraged feedback on the website to ensure it is a useful tool for its members and providers.

Ms. Kim highlighted some legislative activities, noting that CalOptima Health is in the middle of planning for the budget, which is highly influenced by both federal and state legislative actions. She added that Veronica Carpenter, CalOptima Health's Chief Administrative Officer, and Jordan Abushawish, Senior Director, Government Affairs, were in Washington, DC this past week meeting with the Orange County delegation and congressional leaders who are making decisions related to Medicaid budget policies. Ms. Kim invited Ms. Carpenter to share highlights from the meetings in Washington, DC.

Ms. Carpenter reported that CalOptima Health, along with its federal lobbyists at Chamber Hill Strategies, met with 15 Congressional and Senate offices, which included the Orange County delegation. She noted that the meetings served to educate elected officials on the services that CalOptima Health provides for its members and to also voice its opposition to any cuts to the Medicaid program, which will affect its members. Ms. Carpenter added that they heard from several legislative offices that some potential changes to the Medicaid program included bringing back the work requirement for members designated as able bodied. She noted that this change aligns with previous requirements for the Medicaid (Medi-Cal in California) program before the COVID-19 pandemic. Another proposed change is a reduction in the grace period from 90 days to 30 days for the Medi-Cal application timeframes, which aligns with requirements in place before the pandemic. Ms. Carpenter reported that cuts to Medicaid are on the horizon; however, the exact dollar amount is uncertain. While in Washington, DC, staff heard cuts to Medicaid could be anywhere from $50 to $500 million, but the budget discussions are very fluid, and changing minute to minute. Ms. Carpenter noted the federal budget still needs to pass the House and then the Senate and ultimately be signed by the President. She added that staff will keep the Board updated.

Vice Chair Sarmiento provided an update on the Legislative Ad Hoc Committee, which the Board established to address legislative and advocacy issues. He noted that the Legislative Ad Hoc Committee, consisting of himself, Chair Becerra, and Director Garcia Guillen has met twice since its creation in March. Vice Chair Sarmiento reported that the ad hoc committee has been receiving timely updates from Clear Advocacy, CalOptima Health's state lobbyist, and Chamber Hill Strategies, its federal lobbyist. As both the state and federal administrations continue budget negotiations with the state legislature and Congress, CalOptima Health is navigating a highly dynamic and fluid environment. Vice Chair Sarmiento noted that the current environment is unsettling due to the uncertainty and unpredictability. The ad hoc committee recommended and supported CalOptima Health by sending a joint letter with key Orange County safety net partners to the Orange County federal delegation expressing strong opposition

to any proposed cuts to Medicaid. In addition, the ad hoc committee is considering recommending sending a similar letter to the DHCS.

3. Fiscal Year (FY) 2025-2026 Budget and Reserve Planning

Nancy Huang, Chief Financial Officer, presented an overview of the FY 2025-2026 Budget and Reserve Planning noting that she would start with CalOptima Health's budget outlook. Ms. Huang reviewed the proposed budget assumptions, which included a projected decrease in Medi-Cal enrollment and an increase in the average costs for the Medi-Cal population. She reported that for June 2025 the enrollment is at about 910,000 individuals and the forecasted enrollment for June 2026 is about 867,000. She outlined the budget approach, focusing on available information and avoiding speculation on potential policy changes. Ms. Huang provided detailed breakdowns of enrollment, revenue, medical expenses, and administrative expenses.

Ms. Huang also presented an overview of the reserve policy modification, which increased the upper limit from three to four months of capitation revenue. She noted that CalOptima Health will be basing the FY 2025-26 budget on the best information available and will most likely need to come back to the Board after the final budget is presented due to changes that may be on the horizon at both the state and federal levels.

Ms. Huang responded to Board members' comments and questions after considerable discussion. She noted that the full FY 2025-26 budget will be presented at the May 22, 2025, Finance and Audit Committee meeting and then to the full Board for approval at the June 5, 2025, meeting.

ADVISORY COMMITTEE UPDATES

4. Member Advisory Committee and Provider Advisory Committee Updates

Christine Tolbert, Member Advisory Committee (MAC), Chair, reported on the recent and upcoming activities of the MAC and the Provider Advisory Committee (PAC). She provided a quick recap from the April 10, 2025, Joint MAC/PAC meeting, noting that the committees were updated on the health equity and community reinvestment program plan. Ms. Tolbert reported that the committees had good discussions regarding the voice of the members in terms of satisfaction surveys and feedback from members and areas for improvement. The committees also received a walkthrough of the newly redesigned CalOptima Health website and appreciated the user-friendly navigation and useful tools. Ms. Tolbert also noted that it is much easier to find the Board MAC/PAC meetings. She said there were significant discussions about the state and federal budget and appreciated the updates, which also included a legislative bill tracking matrix. Ms. Tolbert added that as CalOptima Health leadership has noted, at the end of the day, work continues even though things seem uncertain. She added that the message rang loud and clear, not only for CalOptima Health, but certainly for all the representatives from various agencies that serve on the MAC/PAC as well as the member representatives.

PUBLIC COMMENTS

- Mary Ellen Stuart, John Henry Foundation: Oral report thanking the CalOptima Health Board and leadership for the workforce development round two grants.

CONSENT CALENDAR

5. Minutes

a. Approve Minutes of the April 3, 2025 Regular Meeting of the CalOptima Health Board of Directors

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6. Approve New CalOptima Health Policy IT.1307 Vulnerability and Patch Management

7. Authorize Amendment of the Data Center Co-location Facility Contract with the County of Orange
This item was pulled from the Consent Calendar for a separate vote.

8. Receive and File:
a. March 2025 Financial Summary
b. Compliance Report
c. Government Affairs Reports
d. CalOptima Health Community Outreach and Program Summary

Action: ***On motion of Director Green, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 5 through 8, minus Agenda Item 7, as presented. (Motion carried 8-0-0; Chair Becerra absent)***

CONSENT CALENDAR

7. Authorize Amendment of the Data Center Co-location Facility Contract with the County of Orange
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.

Action: ***On motion of Director Green, seconded and carried, the Board of Directors: 1.) Ratified the use of the County of Orange Data Center Co-location facility under the same terms and conditions of the expired contract, without a formal written agreement, through July 31, 2025; and 2.) Authorized the Chief Executive Officer, with the assistance of legal counsel, to amend the contract with the County of Orange to update the payment terms and approve the contract term effective August 1, 2025, through July 31, 2028, with two one-year extension options, each exercisable at CalOptima Health's sole discretion. (Motion carried 7-0-0; Chair Becerra absent; Vice Chair Sarmiento recused)***

REPORTS/DISCUSSION ITEMS

9. Approve Actions Related to a Contract with Deloitte to Provide Operational Readiness and Implementation Support for CalOptima Health's Participation in Covered California

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors, pursuant to the result of a formal procurement process, authorized the Chief Executive Officer to execute a contract with Deloitte for the term of May 15, 2025, through March 31, 2027, for Operational Implementation Support and Project Management of CalOptima Health's Covered California product launch. (Motion carried 8-0-0; Chair Becerra absent)***

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10. Approve Actions Related to Covered California Provider Network and Benefit Vendors

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. Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health and left the room during the discussion and vote.

Action: ***On motion of Director Byron, seconded and carried, the Board of Directors: 1.) Approved the proposed Provider Network design for Covered California; 2.) Authorized the Chief Executive Officer, or designee, to negotiate and execute contract amendments to update contract terms, including participation in Covered California, contract duration, and payment terms with the following companies: a.) Liberty Dental Plan of California, Inc.; b.) MedImpact Healthcare Systems, Inc.; c.) Telemedicine Group P.C. dba TeleMed2U; and d.) Vision Service Plan; and 3.) Authorized the Chief Executive Officer, or designee, with the assistance of legal counsel, to make future changes to Covered California benefit provider contracts to comply with statutes, regulations, or sub-regulatory guidance and CalOptima Health policies and procedures. (Motion carried 6-0-0; Chair Becerra absent; Director Helleland and Director Mayorga recused)***

11. Authorize a Pilot Program to Contract with Eligible Community-Based Adult Services Providers to provide Enhanced Care Management-like Services to OneCare Members

Director Garcia Guillen did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director Green, seconded and carried, the Board of Directors: 1.) Authorized a Pilot Program to Contract with Eligible Community-Based Adult Services Providers to Provide Enhanced Care Management-like Services to OneCare Members for the period of July 1, 2025, through December 31, 2026 (Motion carried 7-0-0; Chair Becerra absent; Director Garcia Guillen recused)***

12. Approve Actions Related to Community Based Adult Services Provider Overpayments Arising from a Department of Health Care Services Fee Schedule Error

The clerk read into the record the corrected recommended action, and staff provided additional details regarding this item.

Ms. Kim provided additional details noting that DHCS's fee schedule, published on July 15, 2024, had an incorrect rate for fee-for-service Community Based Adult Services (CBAS) providers for certain procedure codes (H2000, S5102, T1023), which resulted in a 10% increase in fees paid to CBAS providers. Managed Care Plans (MCPs), like CalOptima Health, use the published fee schedules to base their rates paid to providers. DHCS initially asked MCPs to waive the recovery of the overpayments made to CBAS providers for the period of August 1, 2024, through May 31, 2025, but revised the end date to April 30, 2025. Staff estimated a total overpayment to CBAS providers of $5 million, which is now reduced to $4.5 million due to the end date change.

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After considerable discussion, the Board directed staff to bring back the details on how the CBAS providers spent the extra dollars received due to the error in the DHCS's fee schedule.

Directors Byron, Garcia Guillen, and Mayorga abstained on this item.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors authorized the Chief Executive Officer to waive the recovery of overpayments made to Community Based Adult Services providers for the period of August 1, 2024, through ~~May 31, 2025~~April 30, 2025, due to erroneous rate increases in the Department of Health Care Services July 15, 2024, published fee schedule. (Motion carried 5-0-3; Directors Byron, Garcia Guillen, and Mayorga abstained; Chair Becerra absent)*** *Rev. 5/1/2025*

CLOSED SESSION
The Board adjourned to Closed Session at 3:25 p.m. Pursuant to Government Code section 54956.87, subdivision (b) HEALTH PLAN TRADE SECRETS: OneCare and CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Government Code section 54956.9(d)(2): 1 Case.

The Board returned to Open Session at 3:55 p.m., and the Clerk re-established a quorum.

ROLL CALL
Members Present: Supervisor Vicente Sarmiento, Vice Chair; Maura Byron; Supervisor Doug Chaffee; Blair Contratto; Norma García Guillén; Catherine Green, R.N.; Brian Helleland; Jose Mayorga, M.D.
(All Board members participated in person)

Members Absent: Isabel Becerra, Chair; Veronica Kelley (non-voting) (left meeting at 3:40 p.m.)

CLOSED SESSION
Vice Chair Sarmiento noted that the Board met in Closed Session, and there were no reportable actions taken for CS-2 and CS-1, and the Board will hear Agenda Item 13.

REPORTS/DISCUSSION ITEMS
13. Authorize Actions Related to CalOptima Health OneCare Bid for Calendar Year 2026 *(to Follow Closed Session)*

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer (CEO) to submit the OneCare Bid for Calendar Year 2026 and execute contracts with the Centers for Medicare & Medicaid Services and the California Department of Health Care Services; and 2.) Authorized the CEO to amend/execute OneCare Health Network contracts and ancillary provider contracts and take other actions as necessary to implement. (Motion carried 8-0-0; Chair Becerra absent)***

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BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Supervisor Chaffee thanked CalOptima Health staff for attending the Children and Family Fair at Magnolia High School in Anaheim on Saturday, April 26, 2025.

Director Contratto thanked Ms. Katsarov and her team for their work with school districts and ensuring mental health services are available for students.

The Board members thanked staff for their work in support of CalOptima Health's members.

ADJOURNMENT

Hearing no further business, Vice Chair Sarmiento adjourned the meeting at 4:03 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: June 5, 2025

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

February 20, 2025

A Regular Meeting of the CalOptima Health Board of Directors' (Board) Finance and Audit Committee (FAC) was held on February 20, 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 Isabel Becerra called the meeting to order at 3:02 p.m., and Director Blair Contratto led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair; Blair Contratto; Brian Helleland (All members participated in person)

Members Absent: None

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

MANAGEMENT REPORTS

1. Chief Financial Officer Report

Nancy Huang, Chief Financial Officer, provided updates regarding the Department of Health Care Services (DHCS) Calendar Year (CY) 2024 final rates and CY 2025 Medi-Cal draft rates. Upon analysis, staff found that the rates partially addressed CalOptima Health's concerns, thereby decreasing the gap between its cost and utilization data submission and the rates provided by the State.

Staff received CY 2024 final rates from DHCS. The State reversed planned rate reductions for Targeted Provider Rate Increases (TRI) Phase I implementation and member acuity adjustments. After comparing the final rates to the revised rates released in September 2024, staff included a year-to-date true-up of $39 million in the unaudited financials for December 2024.

Furthermore, the CY 2025 draft rates included updates to trend assumptions, CalAIM Community Support Services, and other program changes from the previous version released in October 2024. Ms. Huang noted that the net result shows a favorable impact on revenues compared to the Board-approved Fiscal Year 2024-25 Operating Budget. Of note, one area that will directly impact CY 2025 rates is the implementation of Proposition 35 regarding the Managed Care Organization (MCO) tax. Ms. Huang added that the State

will release a plan on the use of MCO tax revenues in the coming months. Staff will continue to monitor this area and provide additional information as it becomes available.

Ms. Huang provided an update on DHCS submissions, including the CY 2023 DHCS Special Terms and Conditions Medical Loss Ratio (MLR) submission. She noted that staff worked with CalOptima Health's contracted vendor, Provencio, and each of the health networks to complete their MLR templates and submitted the consolidated MLR template and attestation to DHCS on January 15, 2025. In addition, in mid-December, CalOptima Health staff completed its final review of CY 2024 TRI submissions from health networks, attesting to the timely and appropriate distributions of TRI payments to the health networks' sub-capitated providers. Ms. Huang added that CalOptima Health submitted its TRI attestation to DHCS on December 30, 2024.

Lastly, Ms. Huang noted that at the May 5, 2024, meeting, the CalOptima Health Board modified the Board-designated reserve levels from 2.5 to 3.0 months of consolidated monthly revenue and created a separate reserve fund to ensure compliance with its tangible net equity requirements. She added that in light of CalOptima Health's future operational needs and revenue forecasts, staff transferred $50 million from its short-term operating fund to the Board-designated reserve fund in January 2025, increasing the reserve level to 2.8 months of consolidated monthly revenue.

Michael Hunn, Chief Executive Officer, and Ms. Huang responded to committee members' comments and questions.

Director Contratto commented on the great work that staff does regarding CalOptima Health's finances and directed staff to add additional details to show, at a glance, the other ins and outs in the financials, including the Intergovernmental Transfers (IGT) dollars, of which, CalOptima Health only receives 2%.

2. Cybersecurity Update

James Steele, Senior Director, Information Security, presented an update on CalOptima Health's cybersecurity. He noted that CalOptima Health has experienced zero major cybersecurity incidents in the past three months. However, Mr. Steele reported that CalOptima Health has experienced one notable third-party cybersecurity incident in the fourth quarter of CY 2024, PIH Whittier Hospital data breach. He noted that PIH Whittier Hospital data breach did not impact CalOptima Health's systems or data.

Mr. Steele also reviewed two recent cybersecurity news articles. The articles, "*Black Kite Research Finds Certain Ransomware Groups Disproportionately Target Healthcare Organizations"* in the Global News Wire, and "*84% of Healthcare Organizations Detected a Cyberattack in the Past 12 Months"* in the HIPAA Journal. Mr. Steele added that the fallout from the Change Healthcare breach has fundamentally altered how ransomware groups operate, making healthcare organizations prime targets.

Mr. Steele reviewed CalOptima Health's cybersecurity metrics for the fourth quarter of CY 2024 as well as the 2025 security risk assessments that are underway or upcoming. He also reviewed changes with regard to California Assembly Bill 3030 (AB 3030), related to Health Care Services and the use of artificial intelligence (AI), effective January 1, 2025. Mr. Steele noted that all health facilities, clinics, and physician practices in California must disclose to patients when generative AI is used to generate written or verbal communications related to patient clinical information. The goal of AB 3030 is to enhance transparency in health care communications, ensuring patients are aware when AI technologies are utilized in their care. Mr. Steele clarified that AB 3030 applies to communications containing patient clinical information,

defined as information related to a patient's health status and excludes administrative matters, such as appointment scheduling or billing. Mr. Steele added that if AI-generated communication is reviewed and approved by a licensed or certified human healthcare provider, the disclaimer requirement does not apply.

Mr. Steele responded to committee members' questions and comments.

INVESTMENT ADVISORY COMMITTEE UPDATE

3. Treasurer's Report

Ms. Huang presented the Treasurer's Report for the period of October 1, 2024, through December 31, 2024. The portfolio totaled approximately $3.5 billion as of December 31, 2024. Of this amount, $2.3 billion was in CalOptima Health's operating account. Additionally, at the end of December 2024, CalOptima Health's Board-designated reserve fund compliance level was 2.64 and the Statutory Designated Reserve Fund was 1.04. Meketa Investment Group Inc. (Meketa), CalOptima Health's investment advisor, completed an independent review of the monthly investment reports. Meketa reported that all investments were in compliance with sector, issuer, and maturity limits stated in Government Code section 53600 *et seq*. and with CalOptima Health's Board-approved Annual Investment Policy during that period.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

4. Approve the Minutes of the November 21, 2024 Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee and Receive and File Minutes of the October 28, 2024 Special Meeting of the CalOptima Health Board of Directors' Investment Advisory Committee

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

Chair Becerra reordered the agenda to hear Agenda Item 8 at the top of the Information Items.

INFORMATION ITEMS

8. Board Approved Initiatives Report

Yunkyung Kim, Chief Operating Officer, provided background on Board Approved Initiatives. In December 2024, staff included in the regular Board meeting materials, a Quarterly Board-approved Strategic Initiative Summary Report, which is included in today's Finance and Audit Committee (FAC) meeting materials. Ms. Kim noted that staff developed the report based on feedback from Board members, as well as feedback from CalOptima Health's stakeholders regarding the status of Board funded initiatives. She presented a summary report of the initiatives that are funded through Board reserve dollars. Ms. Kim explained that some initiatives are related to community outreach and investments, such as non-operation, non-revenue dollars. The summary report was categorized into community investments, quality investments, and infrastructure capacity investments. Ms. Kim added that this effort is to provide the Board and public with a detailed look at the various Board initiatives and a transparent account of how those dollars are being spent and the status of those initiatives. She shared that during today's meeting, staff will review some of these initiatives to inform the Board and public on how CalOptima Health is structuring these initiatives, as well as an opportunity to receive feedback on how staff can enhance the accountability

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and transparency of the Board-approved initiatives. The first initiative staff will review is the Provider Workforce Development that the Board funded at $50 million dollars.

Provider Workforce Development

Michell Nielsen. Director, Strategic Development, provided key updates on the Provider Workforce Development initiative. Ms. Nielsen reported that two of the five planned programs within this initiative have been implemented. Round one of grant funding for this initiative focused on educational investments to increase supply of health care professionals (non-physician) in Orange County. She added that seven educational institutions received grant funding during the first round. Since awarding these grants, CalOptima Health has received semiannual reports from six of the grantees and is awaiting one progress report from the remaining grantee which is due at the end of February. Ms. Nielsen reported that round two grant funding focused on launching workforce training and development innovation fund solutions. She noted that the priority area for the second round of funding is on increasing the behavioral health workforce serving CalOptima Health members.

Comprehensive Community Cancer Screening

Richard Pitts, D.O., Ph.D., Chief Medical Officer, provided an update on the Community Cancer Screening Grant. The Comprehensive Community Cancer Screening and Support Program aims to create a culture of cancer prevention, early detection, and collaboration with partners to work towards a shared goal of dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have equitable access to high quality care. Dr. Pitts reported that CalOptima Health has executed 15 grant agreements to increase access to cancer screening for CalOptima Health members and completed the first round of grant payments. He added that CalOptima Health hopes to serve all eligible CalOptima Health members, and the total number of members screened will be included in future updates. Dr. Pitts reported that CalOptima Health is looking to improve quality and member experience during cancer screening and treatment procedures and will be providing future updates.

Medi-Cal Provider Rate Increases

Ms. Kim provided an update on the Medi-Cal Provider Rate Increases initiative, noting that the Board authorized staff to set aside $526 million to fund provider rate increases over a 30-month period. This equates to about a $220 million investment per year, which began in July 2024, and at the end of the reporting quarter, CalOptima Health is on schedule. Ms. Kim added that CalOptima Health is adding funding to its provider community of about $18 million per month that is funded by Board-designated reserves. She noted that staff expects this spending to stay fairly consistent throughout the life of this particular investment. Ms. Kim reported on the progress of this initiative, noting that it involved amending contracts with thousands of providers who were excited and responded very quickly. She also noted that some providers have not yet responded to the contract amendments and encouraged any providers listening to the meeting to review the contract amendments. Ms. Kim added that when the Board made this investment, it was with an understanding that these rate increases go toward enhancing access and quality of care for CalOptima Health's members, in addition to maintaining support for its provider community. CalOptima Health has implemented a few things to monitor the impact of these provider rate increases; for example, the Monthly Fast Facts report will report on Provider Network Trends on a quarterly basis by line of business, by provider type, by quarter, and further detail CalOptima Health's provider community. Staff will also look at whether CalOptima Health is gaining or losing providers and the reasons behind those indicators. Ms. Kim shared that CalOptima Health has seen an increase in providers interested in caring for its members and a big decrease in providers expressing concern about their continued ability to care for CalOptima Health members. She also noted that CalOptima Health chose quality scores from CY 2024 to

be the baseline to measure the impact of these provider rate increases on various quality measures, which included the Managed Care Accountability Set scores. DHCS uses these scores to measure CalOptima Health's performance, including the patient satisfaction scores from the CAHPS survey on the Medicare side. In addition, HEDIS metrics give an overall view of improvement in the quality of care that CalOptima Health's members receive and impact to provider satisfaction. Ms. Kim added that staff reviews quality data monthly and reports details to the Quality Assurance Committee on quarterly basis, but the true impact will not be known until the final scores in Fall 2025.

Ms. Kim, Ms. Nielsen, and Dr. Pitts responded to committee members' questions and comments related to the Board Approved Initiatives Report.

The following items were accepted as presented.

5. December 2024 Financial Summary

6. Quarterly Operating and Capital Budget Update

7. CalAIM Program Summary

9. Quarterly Reports to the Finance and Audit Committee
   a. Net Asset Analysis
   b. Enrollment Trend Report
   c. Shared Risk Pool Performance Report
   d. Health Network Financial Report

COMMITTEE MEMBER COMMENTS
There were no committee member comments.

ADJOURNMENT
Hearing no further business, Chair Becerra adjourned the meeting at 4:03 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: May 22, 2025

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
James Steele, Senior Director, Information Security, (714) 497-6046

Recommended Actions

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

Background

CalOptima Health is receiving increasing interest from staff and departments to explore and implement Artificial Intelligence (AI) and Machine Learning (ML) technologies. These tools offer promising opportunities to improve operational efficiency, support healthcare delivery, and enhance member experience. Additionally, numerous laws and regulations are coming out about the usage of AI in healthcare. Without a clear framework, use of AI and ML could present significant risks, including data misuse, bias, and unauthorized access to sensitive information.

In response, CalOptima Health is proactively establishing a secure, transparent, and ethical foundation to guide the safe exploration and use of AI. Policy IT.1002: Artificial Intelligence and Machine Learning provides the necessary structure to manage these technologies in alignment with CalOptima Health's values and commitment to protecting our member's data and privacy.

Discussion

Policy IT.1002: Artificial Intelligence (AI) and Machine Learning (ML) outlines how CalOptima Health will govern the use of AI and ML tools now and in the future. The policy requires that all AI systems be reviewed and approved before use, ensures that decisions affecting members remain under the authority of qualified healthcare professionals, and mandates thorough documentation, testing, and monitoring of AI tools.

The policy includes strong security and privacy safeguards for protected health information and personally identifiable information to protect sensitive information. It prohibits the use of public or unapproved AI platforms for processing sensitive data and ensures compliance with data protection laws.

In addition to security, the policy addresses ethical concerns by requiring fairness, transparency, and human oversight in AI-driven processes. It establishes a governance committee, outlines department-level responsibilities, and mandates regular audits and staff training to promote accountability and compliance.

By implementing this Policy IT.1002: Artificial Intelligence and Machine Learning, CalOptima Health is setting a clear path for responsible AI use that aligns with legal requirements, strengthens the

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organization's cybersecurity posture, and upholds its mission to serve Members with excellence and dignity.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2024-25 Budget.

Rationale for Recommendation
This policy is a new policy being submitted for review, and must be reviewed by the Board of Directors.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennady Leavitt
Board of Directors' Finance and Audit Committee

Attachments
1. CalOptima Health Policy IT.1002: Artificial Intelligence and Machine Learning

/s/ Michael Hunn *05/29/2025*
Authorized Signature **Date**

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Policy:	IT.1002
Title:	**Artificial Intelligence (AI) and Machine Learning (ML)**
Department:	Information Technology
Section:	Cybersecurity
CEO Approval:	*/s/*
Effective Date:	06/01/2025
Revised Date:	Not Applicable
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250605 BOD Review Only

I. PURPOSE

The purpose of this policy is to establish guidelines and principles for the ethical, responsible, and transparent development, deployment, and use of Artificial Intelligence (AI) and Machine Learning (ML) systems within CalOptima Health including appropriate safeguards for Member Protected Health Information (PHI) and Personally Identifiable Information (PII) and compliance with Health Insurance Portability and Accountability Act (HIPAA), Federal, and State Privacy regulations. This policy aims to ensure that these technologies are utilized in ways that align with our mission to "serve Member health with excellence and dignity, respecting the value and needs of each person" by providing equitable, efficient, and high-quality healthcare services, while respecting CalOptima Health Members privacy, rights and promoting fairness, accountability, and transparency.

II. POLICY

A. Policy Scope

1. This policy applies to all employees, contractors, and third-party partners involved in the development, deployment, and management of AI and ML systems within and for the use of CalOptima Health. It specifically limits the use of these technologies to organization-approved systems. These systems will include, but are not limited to, Large Language Models, Generative AI, Intelligent Data Analytics, and AI digital/Meeting Assistance.

B. Ethical AI and ML Development

1. AI and ML systems must be designed and developed in accordance with ethical standards that prioritize Member and employee well-being, dignity, privacy, and rights.

2. Only organization-approved AI and ML technologies can be used, ensuring compliance with ethical, operational and regulatory standards.

C. Transparency and Explainability

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1. The processes and decisions made by AI and ML systems must be transparent and explainable to stakeholders, including Members, healthcare providers, CalOptima employees, and regulatory bodies.

2. Clear documentation of AI and ML models, data sources, and decision-making processes must be maintained for organization-approved technologies to facilitate understanding and accountability. All documentation shall be maintained in accordance with CalOptima Health Policy HH.2022 Record Retention and Access.

D. Data Privacy and Security

1. AI and ML systems must adhere to stringent data privacy and security standards, protecting sensitive CalOptima Health Member information from unauthorized access and breaches.

2. Data used for training and operating AI and ML systems shall be collected and processed in compliance with relevant healthcare data protection laws and regulations, such as HIPAA.

3. Entering sensitive data, including PHI and PII, into any unauthorized or public AI sites and applications is prohibited.

E. Human-Centric AI and ML

1. AI and ML systems shall be designed to augment human capabilities and decision-making in healthcare, not replace human judgment entirely.

2. Healthcare providers shall be provided with the necessary tools and information to understand and control AI and ML interactions, maintaining meaningful human oversight.

3. Decisions regarding the denial of claims or services must always involve a human reviewer. AI and ML systems will not be used to deny, delay or modify health care services based, in whole or in part, on medical necessity. A determination of medical necessity shall be made only by a licensed physician or licensed health care professional competent to evaluate the specific clinical issues involved in the health care services requested by the provider.

4. AI and ML systems used for utilization review or management functions, based on medical necessity, will make its determination based on the enrollee's medical or clinical history, individual circumstances as presented by the requesting provider, and other relevant clinical information contained in the enrollee's medical or clinical record. The system will not base its determination solely on a group dataset.

F. Member Communication

1. CalOptima Health will ensure that clinical communications, if created by AI, disclose the use of AI to the Member unless the communication is reviewed by a license clinical professional.

G. Safety and Reliability

1. AI and ML systems must undergo rigorous testing and validation to ensure their safety, reliability, and robustness in healthcare settings.

2. AI and ML systems must be fairly and equitably applied, and in accordance with regulations and guidance issued by the federal Department of Health and Human Services (HHS).

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3. Continuous monitoring and maintenance shall be implemented to address any issues or failures promptly, ensuring Member safety.

H. Legal

1. Compliance with Laws and Regulations

a. Compliance with Health and Safety Code § 1367.01.

b. Following Guidelines Addressed in The California Attorney General's Office Legal Advisory on the Application of Existing California Law to Artificial Intelligence in Healthcare

i. Compliance with California's Health Consumer Protection Laws (Bus. & Prof. Code , § 17200 et seq., Health & Saf. Code, § 445; Welf. & Inst. Code, §§ 14107, 14107.2, Lab. Code, § 139.3, subds. (a), (e), Sen. Bill No. 1120 (2023-2024), Health & Saf. Code, § 1367.01, subd. (k)(1)(A-K); Ins. Code, § 10123.135, subd. (j)(1)(A-K).) CalOptima Health shall ensure:

a) Does not supplant a licensed health care provider's decision making;

b) Bases decisions on individual enrollees' own medical history and clinical circumstances;

c) Does not discriminate, and is applied fairly and equitably;

d) Is open to inspection and audit by relevant state agencies;

e) Is periodically reviewed and revised to maximize accuracy and reliability;

f) Does not use patient data beyond its intended and stated purpose; and

g) Does not directly or indirectly cause harm to the plan enrollee.

ii. Compliance with California's Anti-Discrimination Laws (Gov. Code, § 11135; Cal. Code Regs., tit. 2, § 14000, subd. (m)(6)(B),(e), (ww)(5), (ii)(1-2), § 14027, subd. (b)(3), § 14025, subd. (a)(3), § 14029, subd. (c)(1, 2), § 14053; see also id. at § 14003, subd. (b); Civ. Code, § 51, subd. (b); Ins. Code § 1861.03 (applying Unruh Act to insurance); Health & Saf. Code, § 1317.3, subd. (b); Gov. Code, § 12900 et seq.)

iii. Compliance with California's Patient Privacy and Autonomy Laws (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164, Civ. Code, §§ 56.10, 56.26, 1798.25; Civ. Code, § 56.05, subd. (s), § 56.06, subds. (a), (b), § 56.101, subds. (a), (c).)

c. Compliance with The Department of Managed Health Care (DMHC) All-Plan Letter (APL) 24-023: (OPL) - Newly Enacted Statutes Impacting Health Plans.

I. Roles and Responsibilities

1. Accountability and Oversight:

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a. Clear lines of accountability must be established for AI and ML system outcomes, ensuring that responsible parties are identifiable and can be held accountable.

b. Ongoing monitoring and management of AI and ML systems will be conducted by the appropriate operational owner or their delegate.

c. Regular audits and assessments of organization-approved AI and ML systems will be conducted to ensure compliance with ethical standards and regulatory requirements.

d. AI and ML systems will not be used to make final decisions on the denial of claims or services. All such decisions must be made by a qualified human representative.

e. A RACI chart will be defined by the AI and ML Governance committee.

III. PROCEDURE

A. Governance Structure

1. Establish an AI and ML Governance Committee responsible for overseeing the implementation and adherence to this policy.

2. The committee will include representatives from relevant departments.

B. Training and Awareness

1. Provide regular training sessions for employees and stakeholders on AI and ML ethics, governance, and responsible use in healthcare.

2. Ensure training includes information on the approved AI and ML technologies and the limitations on using unapproved systems.

C. Incident Reporting and Management

1. Implement a clear process for reporting and managing incidents related to AI and ML systems, including potential ethical breaches, biases, or safety issues.

2. Ensure timely investigation and resolution of reported incidents, with measures taken to prevent future occurrences.

D. Continuous Improvement

1. Regularly review and update this policy to reflect evolving best practices, technological advancements, and regulatory changes.

2. Solicit feedback from stakeholders to identify areas for improvement and ensure the policy remains relevant and effective.

E. Compliance and Enforcement

1. If processing PHI, AI and ML used by CalOptima Health is required to meet HIPAA Privacy Rule as 42 U.S.C. § 1320d et al., 45 C.F.R. Parts 160 and 164.

2. All AI and ML usages are required to meet all federal and state regulatory requirements.

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3. Non-compliance with this policy, including the use of non-approved AI and ML technologies, may result in disciplinary actions, including termination of employment or partnership, depending on the severity of the breach.

4. Regular audits and reviews will be conducted to ensure adherence to the policy, with findings reported to senior management and relevant regulatory bodies as required.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. AI and ML RACI Chart
B. Business and Professions Code § 17200 et seq.
C. California Civil Code §§ 51; 56.05(s); 56.06(a)(b); 56.10; 56.26; 56.101(a)(c); 1798.25
D. California Government Code §§ 11135; 12900 et seq.
E. California Insurance Code §§ 1861.03; 10123.135 (j)(1)(A-K)
F. California Labor Code § 139.3(a)
G. CalOptima Heath Policy HH.2022: Record Retention and Access
H. Department of Managed Health Care (DMHC) All-Plan Letter (APL) 24-023: (OPL) - Newly Enacted Statutes Impacting Health Plans
I. Health and Safety Code §§ 445; 1317.3 (b); 1367.01 (k)(1)(A-K)
J. Health Insurance Portability and Accountability Act (HIPAA)
K. Senate Bill No. 1120 (2023-2024)
L. The California Attorney General's Office Legal Advisory on the Application of Existing California Law to Artificial Intelligence in Healthcare
M. Title 2 California Code of Regulations §§ 14000 (m)(6)(B),(e), (ww)(5), (ii)(1-2); 14027 (b)(3); 1402 (a)(3);14029 (c)(1, 2); 14053; 14003 (b)
N. Title 45 Code of Federal Regulations (CFR) Parts 160 and 164
O. Welfare and Institutions Code, §§ 14107, 14107.2

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2025	IT.1002	Artificial Intelligence (AI) and Machine Learning (ML)	Administrative

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IX. GLOSSARY

Term	Definition
Artificial Intelligence (AI)	An engineered or machine-based system that varies in its level of autonomy and that can, for explicit or implicit objectives, infer from the input it receives how to generate outputs that can influence physical or virtual environments.
Artificial Intelligence (AI) Digital/Meeting Assistance	Encompasses artificial intelligence tools designed to support administrative and collaborative tasks. These tools can automate functions such as meeting scheduling, real-time transcription, note-taking, summarization of discussions, and the assignment or tracking of action items.
Generative Artificial Intelligence (AI)	Refers to artificial intelligence technologies that create original content, including text, images, audio, or video, by learning patterns from existing data. These systems generate outputs that resemble content typically produced by humans.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996.
Human-Centric	An approach that prioritizes human needs, values, and well-being in the design and use of systems, ensuring that technology serves people in a fair, ethical, and understandable way.
Intelligent Data Analytics	Involves the use of artificial intelligence and machine learning techniques to process and analyze large volumes of data. It enables the identification of patterns, trends, and insights, supporting faster and more informed decision-making.
Machine Learning (ML)	A subset of AI that involves training algorithms on data so that they can learn patterns and make predictions or decisions without being explicitly programmed for each task. ML improves over time as it processes more data.
Member	A beneficiary enrolled in a CalOptima Health program.
Personally Identifiable Information (PII)	Any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, religion, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Protected Health Information (PHI)	Has the meaning in Title 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. Individually identifiable health information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or

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Term	Definition
	3. Past, present, or future Payment for the provision of health care to a Member.
Responsible, Accountable, Consulted, Informed (RACI)	A decision-making and role-assignment model that clarifies who is Responsible for doing the work, who is Accountable for the outcome, who needs to be Consulted, and who should be Informed throughout a process or project.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

4. 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-B 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 – B Contract Amendment to the Primary Agreement

Overview

The CalOptima Health Board of Directors Chair signed the finalized CY 2024 - B Contract Amendment in early May 2025 to meet the DHCS deadline of May 6, 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 January 1, 2024. *See* Attachment 3 for further information regarding the changes contained within this amendment.

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

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DHCS' 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 to the CalOptima Health Fiscal Year 2024-25 Operating Budget.

Rationale for Recommendation
CalOptima Health's execution of the CY 2024-B 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-B CalOptima Health Contract Amendment (Primary Agreement + Amendments)
3. Attachment 3_Additional CY 2024-B Contract Amendment Detail

/s/ Michael Hunn *05/29/2025*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 4

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

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

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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 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:

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Exhibit A
SCOPE OF WORK

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

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

V. Americans with Disabilities Act

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

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

Exhibit A, ATTACHMENT I

1.0 Definitions

As used in this Contract, unless otherwise expressly provided 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*.

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

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

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

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

A. Services the Member receives by Contractor;

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

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

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

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

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

Care Management Plan (CMP) means a written plan that is developed with input from the Member and/or their family member(s), parent, legal guardian, Authorized Representative (AR), caregiver, and/or other authorized support person(s) as

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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 C**Y**SHCN 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.

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

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

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

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

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

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

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

Developmental Disability (DD) means, as defined by the Lanterman Developmental Disabilities Services Act (1977) at W&I section 4512(a)(1), a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. This term includes intellectual disability, cerebral palsy, epilepsy, and autism. This term also includes disabling conditions found to be closely related to intellectual disability, but ~~shall~~ **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 ~~three~~ **one** full ~~months' capitation~~ **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(l)(3)(B).

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

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

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

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

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

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

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

Implementation Period means the period of time in which Contractor is undertaking any readiness requirements required by DHCS before performance of the Contract

begins. The Implementation Period begins with DHCS awarding this Contract and extends to the effective date that begins the Operations Period.

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

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

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

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

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

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

Initial Health Appointment (IHA), previously called Initial Health Assessment, means an assessment that must be completed within 120 days of Contractor enrollment for new Members and must include a history of the Member's physical and Behavioral

Health, an identification of risks, an assessment of need for preventive screens or services and health education, and a diagnosis and plan for treatment of any diseases.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.

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

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

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

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

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

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

Minor Consent Services means those Covered Services of a sensitive nature which minors do not need parental consent to access, including but not limited to the following situations:

A. Sexual assault, including rape;

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

C. Pregnancy;

D. Family planning

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

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

G. Outpatient mental health care for minors 12 years of age or older who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924 and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the minors are the alleged victims of incest or Child abuse.

Model of Care (MOC) means Contractor's ~~framework~~ **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 ~~service~~ **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, 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, 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	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Quality Performance Measures means tools that help measure healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.

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

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

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

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

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

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

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

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

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

Safety-Net Provider means any Provider of comprehensive Primary Care or acute hospital inpatient services that provides services to a significant number of Medi-Cal recipients, patients who receives charity, and/or patients who are medically underinsured, in relation to the total number of patients served by the Provider.

School Site means a facility or location used for public kindergarten, elementary, secondary, or postsecondary purposes. “School Site” also includes a location not

owned or operated by a public school, or public school district, if the school or school district provides or arranges for the provision of Medically Necessary treatment of a mental health or Substance Use Disorder to its students at that location, including off-campus clinics, mobile counseling services, and similar locations.

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

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

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

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

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

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

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

Skilled Nursing Facility (SNF) means any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal program.

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

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

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

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

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

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

State means the State of California.

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

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

Street Medicine means a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment that Contractor may offer to their Members. The fundamental approach of Street Medicine is to engage people experiencing unsheltered homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through. Street Medicine utilizes a whole person, patient-centered approach to provide Medically Necessary health care services, as well as address Social Drivers of Health that impede health care access.

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

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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
C**Y**SHCN	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

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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 ~~counties~~ (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties) must have a Dual Special Needs Plan (D-SNP) available to dual eligible Members for contract year 2024 **and 2025** and must **have** ~~provide~~ documentation of the Centers for Medicare & Medicaid approval of the D-SNP by December 2, 2023.

EXHIBIT A, ATTACHMENT I – 1.0 DEFINITIONS

No deliverables listed for this Article.

EXHIBIT A, ATTACHMENT I – 2.0 ACRONYMS

No deliverables listed for this Article.

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

See specific contract Sections below for details.

EXHIBIT A, ATTACHMENT III – 1.1 PLAN ORGANIZATION AND ADMINISTRATION

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

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

EXHIBIT A, ATTACHMENT III – 1.2 FINANCIAL INFORMATION

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

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

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

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

EXHIBIT A, ATTACHMENT III – 2.1 MANAGEMENT INFORMATION SYSTEM

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

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

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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 (C**Y**SHCN).
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.~~; and~~ ~~5) How Contractor will ensure that one Member of the CAC participates in the DHCS Statewide CAC and how Contractor will support Member's attendance and participation in that Committee.~~
R.0196	Submit policies and procedures for providing continuity of care including the completion of Covered Services by Providers and out-of-Network Providers.
R.0197	Submit policies and procedures for performance of Facility Site Reviews (FSR) and Medical Record reviews (FSR Attachments A and B), and performance of Facility Site physical accessibility reviews (FSR Attachment C).
R.0198	Submit the aggregate results of pre-operational Site Reviews to DHCS at the request of DHCS. The aggregate results must include all data elements specified by DHCS.

EXHIBIT A, ATTACHMENT III – 5.3 SCOPE OF SERVICES

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

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Identifier	Operational Readiness Requirement
R.0202	Submit a list of appropriate hospitals available within the Network that provide necessary high-risk pregnancy services.
R.0203	Provide a detailed description of health education system including policies and procedures regarding delivery of services, administration, and oversight.
R.0204	Provide a list and schedule of all health education classes and/or programs.
R.0205	Submit policies and procedures for the provision of Emergency Medical Transportation (EMT), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).
R.0206	Submit policies and procedures that define and describe what mental health services are to be provided by a licensed mental health care Provider.
R.0208	Submit policies and procedures for the provision of Major Organ Transplants as Covered Services.
R.0209	Submit policies and procedures for the provision of Long-Term Care (LTC) as Covered Services.
R.0210	Submit policies and procedures for the provision of services at non-contracted LTC facilities.
R.0211	Submit policies and procedures for conducting a Drug Use Review (DUR).
R.0212	Submit policies and procedures for the UM of covered pharmaceutical services, demonstrating compliance with mental health parity requirements set forth in 42 CFR section 438.900 *et seq.*
R.0213	Submit policies and procedures for the coverage of clinical trials and routine patient care costs.

EXHIBIT A, ATTACHMENT III – 5.4 COMMUNITY BASED ADULT SERVICES

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

Identifier	Operational Readiness Requirement
R.0220	Submit final draft of the written notice to be sent to Members after a CBAS assessment determination that results in a change to the Member's CBAS benefit.
R.0253	Submit all policies and procedures on providing CBAS Emergency Remote Services (ERS).
R.0254	Submit policies and procedures for community participation for Members receiving CBAS.
R.0255	Submit policies and procedures for notifying DHCS of payments made to a CBAS Provider involved in a credible allegation of Fraud.

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

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

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

Identifier	Operational Readiness Requirement
R.0224	Submit executed MOUs, or documentation substantiating Contractor's efforts to negotiate MOUs to coordinate programs and services for Members with LGAs, third-party entities and county programs in Contractor's Service Area, even if Contractor is coordinating care and not financially responsible, to ensure Care Coordination, data sharing, and non-duplicative services for Members, including, but not limited to: 1) LHDs in each County within Contractor's Services Area for the following programs and services: a) CCS; b) Maternal and Child Health (MCH); c) TB Direct Observed Therapy (DOT); and d) Community Health Workers (CHW). 2) WIC agencies in each county within Contractors' Service Area. 3) LGAs such as the County Behavioral Health Department and County Social Services Department, in each county within Contractors' Service Area to assist with coordinating the following programs and services: a) SMHS; b) Alcohol and SUD treatment services, including counties administering State plan Drug Medi-Cal benefits and counties participating in DMC-ODS; and c)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.

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Identifier	Operational Readiness Requirement
R.0225	Submit executed MOUs, or documentation substantiating Contractor's efforts to negotiate MOUs to coordinate programs and services for Members with LGAs, third-party entities, and county programs in Contractor's Service Area, even if Contractor is coordinating care and not financially responsible, to ensure Care Coordination, data sharing, and non-duplicative services for Members, including at a minimum: 1) LEAs for IEPs or IFSPs; 2) California Department of Corrections and Rehabilitation, County Jails, 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** ~~programs~~; ~~d) Area Agencies on Aging (AAA); and~~ ~~e) Caregiver Resource Center (CRC).~~
R.0226	Submit policies and procedures for exchanging Member Information with MHPs and DMC-ODS or county Drug Medi-Cal Programs in compliance with State and federal privacy laws and regulations.
R.0227	Submit policies and procedures for maintaining collaboration among the parties to the MOU and monitoring and assessing the effectiveness of MOUs. Policies and procedures should include the requirement to review its MOUs annually for any needed modifications or renewal of responsibilities and obligations.
R.0228	Submit executed MOUs, or documentation substantiating Contractor's efforts to negotiate MOUs to coordinate programs and services for Members with LGAs in each county within Contractor's Service Area to assist with coordinating, at a minimum, Targeted Case Management (TCM).

EXHIBIT A, ATTACHMENT III – 6.1 EMERGENCY PREPAREDNESS AND RESPONSE

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

EXHIBIT B, BUDGET DETAIL AND PAYMENT PROVISIONS

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

EXHIBIT C, GENERAL TERMS AND CONDITIONS

No deliverables listed for this Exhibit.

EXHIBIT D(f), SPECIAL TERMS AND CONDITIONS

No deliverables listed for this Exhibit.

EXHIBIT E, PROGRAM TERMS AND CONDITIONS

Identifier	Operational Readiness Requirement
R.0234	Submit policies and procedures explaining Contractor's data certification reporting method. Policies and procedures must include a template certification statement.
R.0235	Submit policies and procedures for the treatment of recoveries, including retention policies, process, timeframes, and documentation for reporting, for all recovery of overpayments.
R.0236	Submit policies and procedures for how Contractor will comply with Cost Avoidance and Post-Payment Recovery for Members with Other Healthcare Coverage (OHC).
R.0237	Submit policies and procedures for how Contractor will comply with Third-Party Tort and Worker's Compensation Liability.
R.0238	Submit policies and procedures for how Contractor will comply with an investigation or a prosecution conducted by the Division of Medi-Cal Fraud and Elder Abuse (DMFEA) and/or the United States Department of Justice (US DOJ), including communicating requirements with Subcontractors and Downstream Subcontractors.

EXHIBIT F, CONTRACTOR'S RELEASE

No deliverables listed for this Exhibit.

EXHIBIT G, BUSINESS ASSOCIATE ADDENDUM

No deliverables listed for this Exhibit.

EXHIBIT H, CONFLICT OF INTEREST AVOIDANCE REQUIREMENTS

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

EXHIBIT I, CONTRACTOR'S PARENT GUARANTY REQUIREMENTS

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

EXHIBIT J, DELEGATION REPORTING AND COMPLIANCE PLAN

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

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

No deliverables listed for this Exhibit.

EXHIBIT L, REQUIREMENTS SPECIFIC TO CONTRACTOR

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

Exhibit A, ATTACHMENT III

1.0 Organization

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

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

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

1.1 Plan Organization and Administration

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

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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** **c**~~C~~omply 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).

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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

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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*

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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.

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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

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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

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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.

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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.

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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,

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Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors are subject to the reporting and remittance requirements. The materiality threshold may be based on one or more of the following:

1) Annual Medi-Cal revenue;

2) The Medi-Cal lives for which risk is delegated;

3) The scope of Medi-Cal services for which risk is delegated; or

4) Other factors.

D. Subcontractor**s** and Downstream Subcontractor**s** ~~arrangements~~ that fall below the materiality threshold for an MLR reporting year, as specified by DHCS, are not subject to MLR reporting for that MLR reporting year. DHCS reserves the right to reestablish the threshold annually, may require reporting by certain Subcontractors and Downstream Subcontractors regardless of materiality, and will communicate details of the materiality threshold and subsequent updates and/or changes through APLs or other instruction.

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);

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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; 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.

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

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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(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.

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

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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) Notwithstanding (a)-(c), for Subcontractors and Downstream Subcontractors, premium revenue includes all payments received pursuant to a Subcontractor Agreement or Downstream Subcontractor Agreement, excluding payments received in accordance with 42 CFR section 438.6(d).

2) Taxes, licensing, and regulatory fees for the MLR reporting year must include:

   a) Statutory assessments to defray the operating expenses of any State or federal department;

   b) Examination fees in lieu of premium taxes as specified by State law;

   c) Federal taxes and assessments allocated to Contractor, Subcontractors, or Downstream Subcontractors, as applicable, excluding federal income taxes on investment income, capital gains, and federal employment taxes;

   d) State and local taxes and assessments including:

i. Any industry-wide or subset assessments, other than surcharges on specific claims, paid to the State or a locality directly.

ii. Guaranty fund assessments.

iii. Assessments of State or local industrial boards or other boards for operating expenses, or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by the State.

iv. State or local income, excise, and business taxes, other than premium taxes and State employment and similar taxes and assessments.

v. State or local premium taxes, plus State or local taxes based on reserves, if in lieu of premium taxes.

e) Payments made by Contractor, Subcontractors, and Downstream Subcontractors, as applicable, that are otherwise exempt from federal income taxes, for community benefit expenditures as defined in 45 CFR section 158.162(c), limited to the higher of either:

i. 3 percent of earned premium; or

ii. The highest premium tax rate in the State, multiplied by Contractor's, Subcontractors', or Downstream Subcontractors', as applicable, earned premium in the State.

3) If Contractor, or any Subcontractor or Downstream Subcontractor, is later assumed by another entity that becomes the new Contractor, Subcontractor, or Downstream Subcontractor under this Contract, a Subcontractor Agreement, or a Downstream Subcontractor Agreement, the new Contractor, Subcontractor, or Downstream Subcontractors must report the total amount of the denominator for the entire MLR reporting year, and no amount under this Paragraph for that year may be reported by the ceding Contractor, Subcontractor, or Downstream Subcontractor.

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

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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;

g) Methodology(ies) for allocation of expenditures;

h) Any credibility adjustment applied;

i) The calculated MLR;

j) Any remittance owed to DHCS, if applicable;

k) A comparison of the information reported with the audited financial report required under 42 CFR section 438.3(m);

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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 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.

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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 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

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documents. Record retention requirements are also referenced in Exhibit E of this Contract.

1.2.6 Contractor's Obligations

A. Contractor is required to provide any other financial reports, data, or information not listed above as requested by DHCS to evaluate or monitor Contractor's financial condition.

B. If Contractor's incurred claims reported in accordance with Exhibit A, Attachment III, Subsection 1.2.5, Paragraph C.1.a.iii above includes withholds from payments made to Network Providers, Contractor must provide to DHCS a report, in a form and manner specified by DHCS, detailing the basis for those withholds.

1.2.7 Community Reinvestment Plan and Report

A. Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must annually submit a Community Reinvestment Plan for DHCS' approval that details its anticipated community reinvestment activities, pursuant to Exhibit B, Section 1.17 (*Community Reinvestment*), in a form and manner specified by DHCS through APLs or similar guidance. The Community Reinvestment Plan must detail the expected Members of Contractor's community reinvestment, how they will benefit, and any additional information requested by DHCS. DHCS will make available the parameters for allowable community reinvestment activities through APLs or similar guidance.

B. If Contractor has a Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor, Contractor must require the Fully Delegated Subcontractor and Downstream Fully Delegated Subcontractor to annually submit a Community Reinvestment Plan for approval that details its anticipated community reinvestment activities, pursuant to Exhibit B, Section, 1.17 (*Community Reinvestment*), in a form and manner specified by DHCS through APLs or similar guidance. Contractor must submit the Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's Community Reinvestment Plan to DHCS.

C. Contractor must annually submit a Community Reinvestment Report, including information related to any Fully Delegated Subcontractor's or Downstream Fully Delegated Subcontractor's Community Reinvestment Plan, to DHCS in a form and manner specified by DHCS through APLs or similar guidance. The Community Reinvestment Report must detail

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Contractor's community reinvestment activities in accordance with the Community Reinvestment Plan, and the outcomes thereof. DHCS will make available the minimum information requirements for the report through APLs or similar guidance.

Exhibit A, ATTACHMENT III

1.3 Program Integrity and Compliance Program

1.3.1 Compliance Program
1.3.2 Fraud Prevention Program
1.3.3 Provider Screening, Enrolling, and Credentialing/Recredentialing
1.3.4 Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers
1.3.5 Disclosures
1.3.6 Treatment of Overpayment Recoveries
1.3.7 Federal False Claims Act Compliance and Support

1.3 Program Integrity and Compliance Program

Contractor must establish administrative and management policies and procedures which are designed to prevent and detect Fraud, Waste, and Abuse. In furtherance of this goal, Contractor must establish a Compliance program, a Fraud, Waste, and Abuse prevention program, and other program integrity processes, as set forth in this Exhibit A, Attachment III, Section 1.3 (*Program Integrity and Compliance Program*). In establishing these policies, procedures, and programs, Contractor must meet the requirements of 42 Code of Federal Regulations (CFR) section 438.608.

While Contractor may contract with entities to support Contractor on compliance activities (such as training and auditing), Contractor may not delegate program integrity and compliance program functions to Subcontractors or Downstream Subcontractors.

Contractors must ensure that all Subcontractors and Downstream Subcontractors also have a robust program integrity and compliance program in place. This requirement may be fulfilled by Contractor maintaining all program integrity and compliance program functions on behalf of Subcontractor or Downstream Subcontractor.

1.3.1 Compliance Program

Contractor must have a compliance program that includes, at a minimum, the following elements:

A. A compliance plan which:

1) Outlines the key elements of the compliance program;

2) Includes reference to the standards of conduct or code of conduct;

3) Allows the compliance program to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance;

4) Details how it will implement and maintain elements of the compliance program;

5) Includes the compliance reporting structure and positions of key personnel involved in ensuring compliance, including the compliance officer;

6) References the delegation reporting and compliance plan

7) References policies and procedures operationalizing the compliance program;

8) Is reviewed and approved by the board of director's compliance and oversight committee routinely, but not less than annually; and

9) Is publicly posted on Contractor's website.

B. Standard of conduct or code of conduct must clearly articulate Contractor's commitment to comply with all applicable requirements and standards under this Contract, and all applicable federal and State requirements. It must describe the organizational expectations that all employees, officers, board of directors, Network Providers, Subcontractors, and Downstream Contractors act ethically and have a responsibility in ensuring compliance. Standard of conduct must be approved by Contractor's full board of directors annually.

C. Written policies and procedures which address the following:

1) Detail how elements of the compliance program are operationalized, including the titles of persons responsible for specific activities;

2) Describe how Contractor will oversee all Network Providers, Subcontractors, Downstream Subcontractors, and third-party entities compliance with all applicable terms and conditions of the Contract. See also, Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*); and

3) Outline Contractor's process to ensure policies and procedures are reviewed at least annually and how changes are disseminated to impacted operational areas. Contractor must update the policies and procedures to incorporate changes in applicable laws, regulations, and requirements.

D. A delegation reporting and compliance plan as described in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan*) and Exhibit J *(Delegation Reporting and Compliance Plan)*;

E. The designation of a compliance officer who is responsible for developing, implementing, and ensuring compliance with the requirements and standards under the Contract and who reports directly to the chief executive officer and the board of directors. Contractor's policies and procedures must include the criteria for selecting a compliance officer and a job description, including responsibilities and the authority of this position. The compliance officer must be a full-time employee and must be independent, which means they must not serve in both a compliance and operational role, for example, when the compliance officer is the chief operating officer, finance officer or general counsel.

F. The establishment of a regulatory compliance and oversight committee of the board of directors and at the senior management level charged with overseeing Contractor's compliance program and compliance with the requirements under this Contract. Contractor's policies and procedures must include the criteria for selecting members to the committee. The committee must review the compliance plan on an annual basis. The committee must meet at least quarterly to oversee the compliance program, including, reviewing areas of non-compliance and implementation and monitoring of corrective actions.

G. A system for training and educating the compliance officer, senior management, and employees on federal and State standards and requirements of this Contract. Trainings must address Contractor's standards of conduct, compliance plan, and compliance policies and procedures compliance training completion must be verified such as through a certification or attestation upon training completion and review of the standard of conduct, compliance program, and compliance policies and procedures. Contractor must ensure that training for the compliance officer, senior management, and employees on the compliance program is completed within 90 days of employment and annually thereafter.

H. A system for board members, officers, senior management, and employees to receive training on policies and procedures related to compliance for specific job functions including but not limited to:

1) Compliance officer, senior management, and employees training and education on the overall compliance program, Fraud, Waste, and Abuse, and code of conduct in accordance with Exhibit A, Attachment III, Section 1.3 (*Program Integrity and Compliance Plan*);

2) Network Providers completion of required initial and ongoing Network Provider training within the established timeframes in

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accordance with Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training*), Members' rights as required under Exhibit A, Attachment III, Section 3.2 (*Provider Relations*), and Advanced Directives in accordance with 42 CFR sections 422.128 and 438.3(j) set forth in Exhibit A, Attachment III, Subsection 5.1.1 (*Members Rights and Responsibilities*);

3) Member Services staff completion of required training as set forth in Exhibit A, Attachment III, Subsection 5.1.2 (*Member Services Staff*) and include diversity, equity and inclusion training in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*); and

4) For staff carrying out obligations under MOUs, the training required under Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*)

I. Effective lines of communication between the compliance officer and employees. For example, Contractor must establish a consistent process for distributing and communicating new regulations, regulatory changes, or changes relevant to this Contract. Contractor will communicate this process to all Subcontractors, Downstream Subcontractors, and Network Providers, as applicable. Lines of communication must be accessible to all employees, and include a mechanism to enable anonymous and confidential good faith reporting of potential compliance issues by any employee, Member, Network Provider, Subcontractor, or other person or entity, as they are identified.

J. Enforcement of standards through well-publicized disciplinary guidelines. This includes, but is not limited to:

1) Establishment and implementation of disciplinary policies and procedures that reflect clear and specific disciplinary standards as well as Contractor's expectation for reporting of issues related to noncompliance or illegality; training expectations and disciplinary or enforcement standards when noncompliant activity is found.

2) To demonstrate that disciplinary guidelines are enforced, Contractor must maintain records of disciplinary actions for a period of ten years years at a minimum, including date of and description of violation, date of investigation, findings and date and description disciplinary action.

K. Contractor must develop and maintain effective systems for routine monitoring and auditing, and identification of compliance risks including but not limited to:

1) Dedicated staff for routine internal monitoring and auditing of compliance risks;

2) Methods and tools for assessing whether Contractor activities required under this Contract comply with State and federal law and this Contract ~~f.~~ This includes having methods and tools to evaluate and trend an activity over time to assess noncompliance;

3) Routine and periodic reporting of internal monitoring and auditing activities and results to compliance and oversight committee of the board; and

4) Unannounced audits of Subcontractors and Downstream Subcontractors to assess the compliance with requirements set forth in this Contract as relevant to delegated functions.

L. Contractor must develop and maintain effective systems for prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Contract (42 CFR section 438.608(a)).

1) This includes policies and procedures for constructing and implementing effective Corrective Action plans, including root cause analysis and tailoring Corrective Action plans to address specific compliance concerns;

2) Corrective action plans must be reviewed and signed by the compliance officer and the executive officer responsible for the area subject to the Corrective Action plan;

To demonstrate effective systems to address compliance concerns and implement effective corrective action, Contractor must maintain and publicly post records of Corrective Action plans and the rectifying actions to close out the findings, including but not limited to, committee meeting minutes detailing discussion of corrective action plans and description of outcomes; and

3) Contractor must ensure contractual provisions are in place through Subcontractor Agreements and Downstream Subcontractor Agreements, as relevant, to enforce compliance with Corrective Action plans when they are not met, such as financial sanctions, payment withholds, or liquidated damages.

1.3.2 Fraud Prevention Program

Contractor must have a Fraud prevention program that at a minimum sets forth policies and procedures for the elements identified in this Exhibit A, Attachment III, Subsection 1.3.2 (*Fraud Prevention Program*).

A. Fraud Prevention Officer

Contractor must designate a Fraud prevention officer who is responsible for developing, implementing, and ensuring compliance with Contractor's Fraud prevention program and who reports directly to the chief executive officer and the board of directors. The Fraud prevention officer must attend and participate in DHCS' quarterly program integrity meetings, as scheduled. The same individual may serve as both the compliance officer and the Fraud prevention officer.

B. Notification of Changes in Member's Circumstances

Contractor must promptly notify DHCS when Contractor receives information about changes in a Member's circumstances that may affect the Member's eligibility including changes in the Member's residence, income, insurance status, and death (42 CFR section 438.608(a)(3)). This notification will be in a form and manner specified by DHCS through All Plan Letters (APLs), or other similar instructions.

C. Method to Verify Services Received

Contractor must have a regular method to verify, by sampling or other methods, confirming that services that have been represented to have been delivered by Network Providers were received by Members (42 CFR section 438.608(a)(5)). Contractor must provide proof of compliance with this requirement when requested by DHCS, in a form and manner specified by DHCS through APLs, or other similar instruction.

D. Contractor's Reporting Obligations

In accordance with 42 CFR section 438.608(a)(7), Contractor must refer, investigate, and report all Fraud, Waste, and Abuse activities that

Contractor identifies to DHCS' Program Integrity Unit (PIU), in a manner prescribed by PIU, as follows:

1) Preliminary Fraud, Waste, and Abuse Reports

Contractor must file a preliminary report with DHCS' PIU detailing any suspected Fraud, Waste, or Abuse identified by or reported to Contractor, its Subcontractors, its Downstream Subcontractors, and/or its Network Providers within ten Working Days of Contractor's discovery or notice of such Fraud, Waste, or Abuse. Contractor must submit a preliminary report in accordance with requirements set forth in APLs or other similar instructions. Subsequent to the filing of the preliminary report, Contractor must promptly conduct a complete investigation of all reported or suspected Fraud, Waste, and Abuse activities.

2) Completed Investigation Report

Within ten Working Days of completing its Fraud, Waste, or Abuse investigation (including both Contractor-initiated and DHCS-initiated referrals), Contractor must submit a completed report to DHCS' PIU. This report must include Contractor's findings, actions taken, and include all documentation necessary to support any action taken by Contractor, and any additional documentation as requested by DHCS or other State and federal agencies.

3) Quarterly Fraud, Waste, Abuse Status Report

Contractor must submit a quarterly report to DHCS' PIU on all Fraud, Waste, and Abuse investigative activities ten Working Days after the close of every calendar quarter. The quarterly report must contain the status of all preliminary, active, and completed investigations and must include both Contractor-initiated and DHCS-initiated referrals. In addition to quarterly reports, Contractor must provide updates and available documentation as DHCS may request from time to time.

4) Manner of Report Submission

Contractor must electronically submit each Fraud, Waste, and Abuse report required under the Contract in a manner prescribed by DHCS' PIU. The required reports must include but not be limited to the preliminary Fraud report, the completed investigation report, and the quarterly status report, including all supporting documents,

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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

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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

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Medicare or Medi-Cal programs (42 CFR section 438.610(a)-(c) and APL 21-003).

C. Notification and Termination of Contracts

Contractor must promptly notify DHCS when Contractor receives information about a change in a Network Provider's, Subcontractor's, or Downstream Subcontractor's circumstances that may affect the Network Provider's, Subcontractor's, or Downstream Subcontractor's eligibility to participate in the Medi-Cal managed care program, including the termination of their Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement with Contractor in accordance with this Contract, State and federal law, including 42 CFR section 438.608(a)(4), and APL 21-003.

D. Actions to be taken where Credible Allegation of Fraud

If DHCS, Division of Medi-Cal Fraud and Elder Abuse (DMFEA), or United States Department of Justice (US DOJ), or any other authorized State or federal agency, determines there is a credible allegation of Fraud against Contractor's Subcontractor, Downstream Subcontractor, or Network Provider, Contractor must comply with this Contract, all applicable State and federal laws, APL 15-026, and APL 21-003. Contractor must have procedures in place to immediately suspend payments to Subcontractors, Downstream Subcontractors, and Network Providers for which a State or federal agency determines there is a credible allegation of Fraud (42 CFR section 438.608(a)(8)). In addition, Contractor may conduct additional monitoring, temporarily suspend, and/or terminate the Network Provider, Subcontractor, or Downstream Subcontractor.

1.3.5 Disclosures

In accordance with 42 CFR section 438.608(c), Contractor, its Subcontractors, and its Downstream Subcontractors must:

A. Provide written disclosure of any prohibited affiliation under 42 CFR section 438.610; and

B. Provide written disclosures of information on ownership and control as required under 42 CFR section 455.104.

C. Report and return any payment to DHCS within 60 calendar days of when it has identified any Capitation Payments or other payments it has received or paid in excess of the amounts specified in this Contract.

1.3.6 Treatment of Overpayment Recoveries

A. Retention, Reporting, and Payment of Recoveries

Contractor must comply with guidelines issued by DHCS pertaining to retention policies for the treatment of recoveries of all overpayments from Contractor to a Provider, including for the treatment of recoveries of overpayments due to Fraud, Waste, or Abuse. Contractor must also comply with the process, timeframes, and documentation required for reporting and paying to DHCS the recovery of overpayments, as set forth in APL 23-011. APL 23-011 requires Contractor to notify DHCS of any identified or recovered overpayments to a Provider due to potential fraud, waste or abuse. Contractor must notify its Managed Care Operations Division (MCOD) Contract Manager (CM) within 10 calendar days of the date that the overpayment, and the DHCS Audits and Investigations Unit regardless of the amount.

Contractor must split equally overpayment recoveries of $25 million or more with DHCS. Contractor must report an overpayment of $25 million or more to DHCS through their assigned ~~Managed Care Operations Division (~~MCOD~~) Contract Manager (~~CM~~) Within~~ **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

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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.

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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;

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6) Medi-Cal FFS Treatment Authorization Request data;

7) California Children's Services (CCS) Program data;

8) Targeted Case Management (TCM) data;

9) Pharmacy claims data;

10) Risk Tier assignment data;

11) Authorization and referral data; and

12) Medical record information including case notes.

Contractor must have processes in place for utilizing all data made available in order to meet the requirements for and support of Care Coordination, other administrative functions of the Contract with DHCS, and Operational Readiness Requirements and Deliverables as described in Exhibit A, Attachment II.

D. Contractor must implement and maintain a publicly accessible, standards-based Patient Access Application Programming Interface (API), and a Provider Directory API, as described in 42 CFR sections 431.60 and 431.70, and in APL 22-026. Contractor must operate the API in the manner specified in 45 CFR section 170.215 and include information per 42 CFR section 438.242(b)(5) and (6).

2.1.2 Encounter Data Reporting

A. Contractor must maintain a MIS that consumes Encounter Data and/or claims data and transmits Encounter Data, including allowed amounts and paid amounts as required, to DHCS in compliance with 42 CFR sections 438.242 and 438.818 and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Encounter Data to DHCS, as defined in State and federal law, APLs, and this Contract, for all items and services furnished to a Member under this Contract, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers to submit

claims and Encounter Data to Contractor to ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Encounter Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, Downstream Subcontractor, and out-of-Network Provider Encounter Data regardless of contracting arrangements or whether the Network Provider, Subcontractor, Downstream Subcontractor, or out-of-Network Provider is reimbursed on a FFS or capitated basis.

D. Contractor must submit complete, accurate, reasonable, and timely Encounter Data within six Working Days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS.

E. DHCS will review and validate Contractor's Encounter Data, including Encounter Data submitted by Contractor on behalf of its Subcontractors, Downstream Subcontractors, and Network Providers, for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Encounter Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Encounter Data, Contractor must ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Encounter Data.

G. DHCS or its agent will periodically, but not less frequently than once every three years, conduct an independent audit of the Encounter Data submitted by, or on behalf of, Contractor, in accordance with 42 CFR section 438.602(e). Contractor must comply with the requirements set forth in Exhibit A, Attachment III, Subsection 2.2.9.E (*Encounter Data Validation*).

2.1.3 Participation in the State Drug Rebate Program

A. Contractor must participate in the federal and State drug rebate program by including all utilization data for both current and retroactive outpatient drugs in its Encounter Data as necessary to meet federal requirements in 42 United States Code (USC) section 1396r - 8(k)(2).

1) Encounter Data for outpatient drugs must comply with 42 USC section 1396r - 8(b)(1)(A); and

2) All outpatient drug Encounter Data must include, at a minimum, the total number of units of each dosage form, strength, and package size, by 11 numeric digit National Drug Code (NDC), for each claim, including eligible Physician administered drug claims.

B. Pursuant to 42 CFR section 438.3(s), Contractor must ensure that Encounter Data for outpatient drugs from participating organizations or covered entities in the federal 340B program contains DHCS-required identifiers to maintain compliance with the requirements of 42 USC section 256b(a)(5)(A)(i). Contractor must also comply with the provisions of Welfare and Institutions Code (W&I) section 14105.46.

C. Contractor must assist DHCS in resolving manufacturer rebate disputes related to Network Provider Data or Encounter Data submissions. Encounter Data identified by DHCS or Contractor as having inaccurate or incomplete units, NDCs, procedure codes, 340B identifiers, or other data elements necessary to resolve manufacturer drug rebate disputes are required to be corrected and resubmitted in compliance with APLs.

2.1.4 Network Provider Data Reporting

A. Contractor must maintain a MIS that collects and transmits Network Provider Data to DHCS in compliance with 42 CFR sections 438.207, 438.604(a)(5), and 438.606, and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Network Provider Data, Subcontractor data, and Downstream Subcontractor data to DHCS, as defined in State and federal law, APLs, DHCS 274 companion guide, and this Contract, that accurately represents Contractor's Network, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, and Downstream Subcontractors to submit Network Provider Data to Contractor to ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Network Provider Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and

timeliness of all Network Provider, Subcontractor, and Downstream Subcontractor Network Provider Data regardless of contracting arrangements.

D. Contractor must submit complete, accurate, reasonable, and timely Network Provider Data within ten calendar days following the end of each month, or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Network Provider Data as set forth in 42 CFR section 438.606. Subcontractors, Downstream Subcontractors and Network Providers must comply with this Section for submission of Network Provider Data to Contractor.

E. DHCS will review and validate Contractor's Network Provider Data for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Network Provider Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Network Provider Data, Contractor must ensure that corrected Network Provider Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Network Provider Data.

2.1.5 Program Data Reporting

A. Contractor must maintain a MIS that consumes and transmits Program Data to DHCS in compliance with Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Program Data to DHCS, as defined in State and federal law, APLs, and this Contract, including, but not limited to, all Grievances, Appeals, referrals, out-of-Network requests, medical exemption request denial reports and other continuity of care requests, and Primary Care Provider (PCP) and Risk Tier assignments received or determined by Contractor, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers to submit

Program Data to Contractor to ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Program Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, Downstream Subcontractor, and out-of-Network Provider Program Data regardless of contracting arrangements.

D. Contractor must submit complete, accurate, reasonable, and timely Program Data within ten calendar days following the end of each month, or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Program Data as set forth in 42 CFR section 438.606. Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers must comply with this Subsection for submission of Program Data to Contractor.

E. DHCS will review and validate Contractor's Program Data for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Program Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Program Data, Contractor must ensure that corrected Program Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Program Data.

2.1.6 Template Data Reporting

A. Contractor must maintain a MIS that collects and reports Template Data to DHCS in compliance with Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Template Data to DHCS, as defined in State and federal law, APLs, and this Contract, for all items and services furnished to a Member under this Contract, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, and Downstream Subcontractors to submit Template Data to Contractor to

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ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting systems, sufficient to ensure Template Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, and Downstream Subcontractor Template Data regardless of contracting arrangements.

D. Contractor must submit complete, accurate, reasonable, and timely Template Data on a regular basis, or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Template Data as set forth in 42 CFR section 438.606. Subcontractors, Downstream Subcontractors, and Network Providers must comply with this Subsection for submission of Template Data to Contractor.

E. DHCS will review and validate Contractor's Template Data for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Template Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Template Data, Contractor must ensure that corrected Template Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Template Data.

2.1.7 Management Information System/Data Audits

Contractor must conduct MIS and data audits to the extent directed by DHCS, in accordance with this Contract, APLs, or other similar instructions which will be no less frequently than once every three years.

2.1.8 Management Information System/Data Correspondence

When DHCS provides Contractor with written notice of any problems or deficiencies related to the submittal of data to DHCS, or of any changes or clarifications related to Contractor's MIS system, Contractor must submit to DHCS a Corrective Action plan with measurable benchmarks within 15 calendar days from the date of DHCS' written notice to Contractor. DHCS will approve Contractor's Corrective Action plan or request revisions within 30 calendar days of receipt of Contractor's Corrective Action plan. If DHCS requests revisions, Contractor must submit a revised Corrective Action plan for DHCS' approval within 15 calendar days after receipt of the request. Contractor's failure to

complete the Corrective Action plan as approved by DHCS will subject it to sanctions, pursuant to Exhibit E, Section 1.19 (*Sanctions*). DHCS may publicly disclose on the DHCS website any Contractors that have entered into Corrective Action plans or have been subject to sanctions due to non-compliance under this Section.

2.1.9. Tracking and Submitting Alternative Format Selections

A. Contractor must have and maintain systems that are able to, at a minimum, perform the following functions:

1) Collect and store Member Alternative Format Selection (AFS), as well as the AFS of a Member's AR;

2) Share Member AFS data with DHCS as specified in the Alternative Format Data Process Guide included in APL 22-002; and

3) Track Member's AR AFS data and submit to DHCS when requested.

B. Contractor must submit all Member AFS data that has been collected in a one-time file upload to the DHCS Alternate Formats database, in the time and manner specified in APL 22-002.

C. After Contractor's one-time file upload is completed, Contractor must submit to DHCS all new Member AFS at the time of the Member's request. Contractor must send submissions online through the AFS application system, or by calling the AFS Helpline at (833) 284-0040.

D. DHCS will share Member AFS data with Contractor on an ongoing basis. DHCS will send Contractor a weekly AFS file from the DHCS Alternative Format Database. The DHCS weekly file data elements and file path are included in the APL 22-002 AFS Technical Guidance attachment. Contractor must utilize the weekly DHCS AFS file data to update their records and provide Member materials in the requested alternative formats.

E. Contractor must submit to DHCS policies and procedures for collecting and sharing AFS data in accordance with the requirements in APL 22-002.

2.1.10 Interoperability Application Programming Interface System Requirements

A. In order to ensure Contractor applies the same standards for Encounter Data contained in Exhibit A, Attachment III, Section 2.1.2 (*Encounter Data*

Reporting), to data collected and made available through its API, Contractor must verify that data collected from Network Providers, Subcontractors, and Downstream Subcontractors to be made available through the API is complete, accurate, reasonable, and timely, and collected in accordance with the oversight and monitoring requirements in APL 22-026. Contractor must make all collected data available to DHCS and CMS, upon request.

B. Contractor must conduct routine testing and monitoring of its API functions, and applying system updates as appropriate, to ensure that the API is compliant and functional.

C. Contractor may deny or discontinue any third-party application connection to its API if Contractor determines that continued access presents an unacceptable level of risk to the security of protected health information on its systems. Contractor's determination must be made in accordance with the requirements provided in APL 22-026.

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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 (C**Y**SHCN), Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions.

The QIHEC's responsibilities include the following:

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1) Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other Contractor committees such as the Community Advisory Committee (CAC);

2) Institute actions to address performance deficiencies, including policy recommendations; and

3) Ensure appropriate follow-up of identified performance deficiencies.

B. Contractor must ensure Member confidentiality is maintained in QI discussions and ensure avoidance of conflict of interest among the QIHEC members.

C. Contractor must ensure that the QIHEC meets at least quarterly, and more frequently if needed. A written summary of QIHEC activities, as well as QIHEC activities of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, findings, recommendations, and actions must be prepared after each meeting and submitted to Contractor's Governing Board. Contractor must also submit the written summary to DHCS ~~upon request~~ **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

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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

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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;

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

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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.

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In accordance with W&I section 14184.203, Contractor must also ensure that all its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors have full NCQA HPA and Health Equity Accreditation by no later than January 1, 2026. Contractor must also ensure all its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors maintain full NCQA HPA and Health Equity Accreditation throughout the term of this Contract. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also complete additional NCQA accreditation programs as directed by DHCS.

Contractor must provide DHCS with the following components of Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's NCQA HPA and Health Equity Accreditation status and reviews within 30 calendar days of the receipt of the completed report from NCQA:

A. Accreditation status;

B. Survey type;

C. Results of the review;

D. Healthcare Effectiveness Data and Information Set (HEDIS ®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS ®) summary level data;

E. Recommended actions or improvements;

F. Corrective Action plans and summaries of findings; and

G. Expiration date of the accreditation.

Contractor must notify DHCS of the date of its NCQA site visit within 15 calendar days of confirmation of the site visit by NCQA. Contractor must make available all written materials submitted to NCQA available to DHCS and allow DHCS representative(s) to participate in the NCQA audit activities, including but not limited to, the NCQA site visit.

Contractor must notify DHCS of any change in NCQA HPA and Health Equity Accreditation status within 30 calendar days of receipt of the final NCQA report. In addition to complying with the Corrective Actions imposed by NCQA, Contractor must also comply with any additional Corrective Actions imposed by DHCS to address a change in Contractor's accreditation status.

If Contractor fails to obtain or maintain its HPA or Health Equity Accreditation status within the timeframe described above and anytime thereafter, Contractor will be subject to Corrective Actions by DHCS, including but not limited to, the actions set forth in Exhibit E, Sections 1.16 (*Termination*), 1.19 (*Sanctions*), and 1.20 (*Liquidated Damages*).

Contractor must have policies and procedures in place to oversee the HPA and Health Equity Accreditation status of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors throughout the term of this Contract. Contractor must have policies and procedures in place to subject its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors to Corrective Actions if Contractor's Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor fails to maintain its HPA and Health Equity Accreditation status, including, but not limited to, termination of Subcontractor Agreements or Downstream Subcontractor Agreements with Fully Delegated Subcontractors or Downstream Fully Delegated Subcontractors, sanctions, and damages.

2.2.9 External Quality Review Requirements

At least annually or more frequently as directed by DHCS, Contractor must cooperate with and assist the External Quality Review Organization (EQRO) designated by DHCS in conducting its EQR reviews of Contractor in accordance with 42 USC section 1396u-2(c)(2), 42 CFR section 438.310 *et seq.*, and 22 CCR section 53860(d).

Contractor must comply with all requirements set forth in 42 CFR section 438.310 *et seq*., the forthcoming APL, and the Centers for Medicare & Medicaid Services (CMS) EQR protocols, which provide detailed instructions on how to complete the EQR activities.

In addition, Contractor must also comply with the following requirements:

A. Quality Performance Measures

On an annual basis, Contractor must track and report on a set of Quality Performance Measures and Health Equity measures identified by DHCS in accordance with all of the following requirements:

1) Contractor must work with the EQRO to conduct an onsite assessment of the Quality Measure Compliance Audit and DHCS-required Quality Performance Measures;

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2) Contractor must calculate and report all required Quality Performance Measures and Health Equity measures at the county or regional reporting unit level and possibly Skilled Nursing Facility (SNF) level as directed by DHCS. Contractor must separately report to DHCS all required performance measure results at the county or reporting unit level and SNF level for certain measures for its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors

   a) Contractor must calculate performance measure rates, to be verified by the EQRO;

   b) Contractor must report audited results on the required performance measures to DHCS no later than June 15 of each year or on another date as established by DHCS. Contractor must initiate reporting on required Quality Performance Measures for the reporting cycle following the first year of this Contract operation;

3) Contractor must meet or exceed the DHCS-established Minimum Performance Level (MPL) for each required Quality Performance Measure and Health Equity measure selected by DHCS. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors whose rates Contractor separately reports to DHCS also meet or exceed the DHCS-established MPL for each required Quality Performance Measure and Health Equity measure selected by DHCS.

4) Contractor must meet Health Disparity reduction targets for specific populations and measures as identified by DHCS.

5) In accordance with 42 CFR section 438.700 *et seq.*, W&I section 14197.7, and Exhibit E, DHCS may impose financial sanctions, administrative sanctions, and/or Corrective Actions on Contractor for failure to meet or exceed required MPLs as detailed in APL 23-012. DHCS may require Contractor to make changes to its executive personnel if a Contractor has persistent and pervasive poor performance as evidenced by multiple performance measures consistently below the MPL over multiple years. DHCS may also limit Contractor's Service Area expansion or suspend Member Enrollment based on Contractor's persistent and pervasive poor performance on Quality Performance Measures.

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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;

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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

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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** ~~Department~~ in its effort to implement the California Children and Youth Behavioral Health Initiative.

G. School-Based Services

To facilitate the provision of Medically Necessary services to Children, Contractor must collaborate with, and, by January 1, 2025 execute, an

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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

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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.

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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

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K. All of Contractor's authorization requirements must comply with the requirements for parity in mental health and SUD benefits in 42 CFR section 438.900, et seq.

2.3.2 Timeframes for Medical Authorization

A. Emergency Services: Contractor must not require Prior Authorization for Emergency Services for complaints or conditions that a prudent layperson would determine could seriously jeopardize their physical or mental health.

B. Post-Stabilization Care Services: Contractor must respond to a Network Provider's or out-of-Network Provider's request for authorization for Post-Stabilization Care Services within 30 minutes or the service is deemed approved, in accordance with All Plan Letter (APL) 23-009.

C. Non-Urgent Care Following an Exam in the Emergency Room: Contractor must respond to a Provider's request for Post-Stabilization Care Services within 30 minutes or the service is deemed approved.

D. Retrospective Review Authorization Request for Treatment Received: Contractor must accept requests for Retrospective Review authorization within a reasonably established time limit, not to exceed 365 calendar days from the date of service. Contractor must communicate decisions to the Provider and to the Member who received the services or to the Member's Authorized Representative (AR) within 30 calendar days of the receipt of information that is reasonably necessary to make this determination, in accordance with 42 CFR section 438.404(a) and H&S section 1367.01(h)(1).

E. Routine Authorizations: Contractor must respond to routine requests and concurrent requests as expeditiously as the Member's condition requires, but no longer than five Working Days from receipt of the information reasonably necessary and requested by Contractor to render a decision, and no longer than 14 calendar days from Contractor's receipt of the request, in accordance with 42 CFR section 438.210 and H&S section 1367.01.

F. Expedited Authorizations: Contractor must make expedited authorization decisions for service requests where a Member's Provider indicates, or Contractor, Subcontractor, Downstream Subcontractor, or Network Provider determines that, following the standard timeframe for Prior Authorizations and concurrent requests could seriously jeopardize the Member's life; health; or ability to attain, maintain, or regain maximum function, in accordance with 42 CFR section 438.210 and H&S section

1367.01. Contractor must provide its authorization decision as expeditiously as the Member's health condition requires, but no longer than 72 hours after Contractor's receipt of the request for services. All Contractors must also expedite Prior Authorization requests for Members who are transitioning from an acute care hospital to all settings including Contractor chosen Community Supports and make an authorization decision in a timeframe that is appropriate for the nature of the Member's condition but is no longer than 72 hours after Contractor's receipt of all information needed to make an authorization decision.

G. Hospice Services: Contractor may only require Prior Authorization for inpatient hospice care. Contractor must respond to inpatient hospice care authorization requests in accordance with 22 CCR section 51003 and APLs.

H. Therapeutic Enteral Formula: Contractor must comply with all timeframes for medical authorization of Medically Necessary therapeutic enteral formula billed on a medical or institutional claim and the equipment and supplies necessary for delivery of enteral formula billed on a medical or institutional claim, as set forth in all applicable DHCS APLs, Welfare and Institutions Code (W&I) section 14103.6, and H&S section 1367.01.

I. Physician Administered Drugs: For medical authorization of Medically Necessary physician administered drugs billed on a medical or institutional claim, Contractor must comply with the same timeframes as other medical services, at set out in this subsection.

2.3.3 Review of Utilization Data

A. Contractor must include within the UM program mechanisms to detect both under- and over-utilization of health care services including Behavioral Health Services. Contractor's internal reporting mechanisms used to detect Member utilization and Provider prescribing patterns must be reported to DHCS no later than 30 calendar days after the beginning of each calendar year and upon request.

B. Contractor must monitor utilization data to appropriately identify Members eligible for Enhanced Care Management (ECM) and applicable Community Supports as specified in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management)* and Subsection 4.5.6 (*Identifying Members for Community Supports)*.

C. Contractor must monitor and track Non-specialty Mental Health Services (NSMHS) utilization data for both Members. Upon request, Contractor must submit data to DHCS.

2.3.4 Delegating Utilization Management Activities

Contractor may delegate UM activities. If Contractor delegates any UM activities, Contractor must comply with Exhibit A, Attachment III, Subsection 2.2.5 (*Subcontractor and Downstream Subcontractor Quality Improvement Activities*).

Exhibit A, ATTACHMENT III

3.0 Providers, Network Providers, Subcontractors, and Downstream Subcontractors

DHCS is committed to ensuring that all Contractors are aware of their obligations under this Contract and are committed to being accountable not only for their own obligations, but for those of their Subcontractors and Downstream Subcontractors for delegated functions. In this Article, DHCS includes provisions requiring Contractors to disclose what entities provide delegated functions through Subcontractor Agreements and Downstream Subcontractor Agreements as applicable.

In addition, Contractors are to demonstrate that they have robust compliance, monitoring, and oversight programs, including for all delegated entities to ensure Members receive quality care and have access to services. This Article requires Contractors to not only disclose delegation arrangements but include justification for the use of delegated entities to ensure that the Member's experience and outcomes are front and center. DHCS is particularly focused on those entities that take risk; thus this Article includes provisions requiring reporting of Subcontractors and Downstream Subcontractors that assume responsibility for taking that risk and managing the health care of a portion of assigned lives.

This Article articulates DHCS' commitment in moving the delivery system towards value-based payment. Contractors are to report on the proportion of spend that is tied to value. In addition, Contractors are to implement Financial Arrangements that link payments to value in the form of higher quality of care, better health care outcomes, and lower cost of care. Such arrangements include, but are not limited to, incentive payment arrangements that reward Providers for high or improved performance on selected measures or benchmarks. Finally, Contractors are to report on the proportion of spend on Primary Care specifically in an effort to encourage investment in Primary Care as appropriate.

3.1 Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties

3.1.1 Overview of Contractor's Duties and Obligations
3.1.2 DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements
3.1.3 Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan
3.1.4 Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance
3.1.5 Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements
3.1.6 Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers
3.1.7 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Federally Qualified Health Centers and Rural Health Clinics
3.1.8 Network Provider Agreements with Safety-Net Providers
3.1.9 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments
3.1.10 Nondiscrimination in Provider Contracts
3.1.11 Public Records
3.1.12 Requirement to Post

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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*

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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

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Downstream Subcontractor Agreements with Downstream Fully Delegated Subcontractors.

b) For Partially Delegated Subcontractors and Administrative Subcontractors, and Downstream Partially Delegated Subcontractors and Downstream Administrative Subcontractors, Contractor must submit all Subcontractor Agreements and Downstream Subcontractor Agreements templates, and any amendments thereto, to DHCS for review and approval prior to execution of the Subcontractor Agreement or Downstream Subcontractor Agreement.

2) Within 60 calendar days of receipt, DHCS will make all reasonable efforts to approve in writing the use of Subcontractor Agreement and Downstream Subcontractor Agreement templates ~~and/or actual proposed Subcontractor Agreements and Downstream Subcontractor Agreements~~ submitted by Contractor. DHCS will provide Contractor with a written explanation indicating whether the template ~~and/or actual proposed Subcontractor Agreement or Downstream Subcontractor Agreement~~ is approved, disapproved, or an estimated date for completion of DHCS review. If DHCS does not complete its review of the submitted material within 60 calendar days of receipt, or by DHCS estimated date of completion, whichever is later, Contractor may elect to implement or use the template ~~and/or actual proposed Subcontractor Agreement or Downstream Subcontractor Agreement~~ at Contractor's sole risk and subject to possible subsequent disapproval by DHCS.

3.1.3 Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan

A. Content of Delegation Reporting and Compliance Plan

Contractor must report its delegation and compliance plan using the templates provided in Exhibit J *(Delegation Reporting and Compliance Plan),* which includes, but is not limited to, the following:

1) All Contractor's contractual relationships with Subcontractors and Downstream Subcontractors;

2) Contractor's oversight responsibilities for all delegated obligations; and

3) How Contractor intends to oversee all delegated activities, including, but not limited to, details regarding key personnel who will be overseeing each delegated function.

B. Timing of Submission

Contractor must submit its delegation reporting and compliance plan to DHCS as follows:

1) During the operational readiness period;

2) Annually, whether or not changes have been made to its delegation structure; and

3) Anytime there is a change in the delegation reporting and compliance plan, including but not limited to a change in a Subcontractor and/or a change in the scope of the delegation.

The report must be submitted within 30 calendar days from either the beginning of the annual reporting period or any change, as identified above.

3.1.4 Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance

Contractor must maintain policies and procedures approved by DHCS to ensure that Network Providers, Subcontractors, and Downstream Subcontractors fully comply with all applicable terms and conditions of this Contract and all duties delegated to Subcontractors and Downstream Subcontractors as set forth above. Contractor must evaluate each prospective Network Provider's, Subcontractor's, and Downstream Subcontractor's ability to perform the contracted services or functions, must oversee and remain responsible and accountable for any services or functions undertaken by a Network Provider, Subcontractor, or Downstream Subcontractor, and must meet all applicable requirements set forth in State and federal law, regulation, any APLs or DHCS guidance, and this Contract.

3.1.5 Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements

A. Network Provider Agreement Requirements

Network Provider Agreements must contain the following provisions:

1) Specification of the Covered Services to be ordered, referred, or rendered;

2) The term of the agreement, including the beginning and ending dates as well as methods of extension, renegotiation, phaseout, and termination, if any;

3) Full disclosure of the method and amount of compensation or other consideration to be received by Network Provider;

4) Specification that the agreement will be governed by and construed in accordance with all applicable laws and regulations governing the Contract, including but not limited to, Knox-Keene Health Care Service Plan Act of 1975 (KKA), Health and Safety Code (H&S) section 1340 *et seq*. (unless excluded under this Contract); Welfare and Institutions Code (W&I) sections 14000 and 14200 *et seq.*; 28 California Code of Regulations (CCR) section 1300.43 *et seq.*; and 22 CCR sections 53800 *et seq.*, 22 CCR sections 53900 *et seq*;

5) Network Provider will comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, including but not limited to, all applicable federal and State Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, APLs, and provisions of this Contract;

6) Network Provider will submit to Contractor, either directly or through a Subcontractor or Downstream Subcontractor as applicable, complete, accurate, reasonable, and timely Encounter Data and Provider Data, and any other reports or data as requested by Contractor, in order for Contractor to meet its data reporting requirements to DHCS;

7) Network Provider will maintain and make available to DHCS, upon request, copies of all contracts it enters into related to ordering, referring, or rendering Covered Services under the Network Provider Agreement, and will ensure that all such contracts are in writing;

8) Network Provider will make all of its premises, facilities, equipment, books, records, contracts, and computer and other electronic systems pertaining to the Covered Services ordered, referred, or rendered under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access

Requirements and State's Right to Monitor, as set forth in Exhibit E, Section 1.22 (*Inspection and Audit of Records and Facilities*), as follows:

a) In accordance with inspections and audits, as directed by DHCS, The Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), the Department of Managed Health Care (DMHC), or their designees; and

b) At all reasonable times at Network Provider's place of business or at such other mutually agreeable location in California.

9) Network Provider will maintain all of its books and records, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term annual of at least ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later;

10) Network Provider will timely gather, preserve and provide to DHCS, CMS, the Division of Medi-Cal Fraud and Elder Abuse (DMFEA), and any authorized State or federal regulatory agencies, any records in Network Provider's possession, in accordance with Exhibit E, Section 1.27 (*Litigation Support*);

11) Network Provider will assist Contractor, or if applicable a Subcontractor or Downstream Subcontractor, in the transfer of Member's care in accordance with Exhibit E, Section 1.17 (*Phaseout Requirements*) in the event of Contract termination, or in the event of termination of the Network Provider Agreement for any reason;

12) Network Providers will be terminated, or subject to other actions, fines, and/or penalties, if DHCS or Contractor determine that the Network Provider has not performed satisfactorily;

13) Network Provider will hold harmless both the State and Members in the event Contractor or, if applicable a Subcontractor or Downstream Subcontractor, cannot or will not pay for Covered Services ordered, referred, or rendered by Network Provider pursuant to the Network Provider Agreement;

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14) Network Provider will not bill a Member for Medi-Cal Covered Services;

15) Contractor must inform Network Provider of prospective requirements added by State or federal law or DHCS related to this Contract that impact obligations undertaken through the Network Provider Agreement before the requirement would be effective, and agreement by Network Provider to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

16) Network Provider must ensure that cultural competency/humility, sensitivity, Health Equity, and diversity training is provided for employees and staff at key points of contact with Members in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*);

17) Network Provider must provide interpreter services for Members and comply with language assistance standards developed pursuant to H&S section 1367.04;

18) Network Provider must notify Contractor, and Contractor's Subcontractor or Downstream Subcontractor, within ten Working Days of any suspected Fraud, Waste, or Abuse and a provision that allows Contractor to share such information with DHCS in accordance with Exhibit A, Attachment III, Subsection 1.3.2.D (*Contractor's Reporting Obligations*) and Subsection 1.3.2.D.6 (*Confidentiality*);

19) Network Provider must report to Contractor, or Contractor's Subcontractor or Downstream Subcontractor, when it has received an overpayment; return the overpayment to Contractor, or Contractor's Subcontractor or Downstream Subcontractor, within 60 calendar days of the date the overpayment was identified; and notify Contractor, or Contractor's Subcontractor or Downstream Subcontractor, in writing of the reason for the overpayment in accordance with Exhibit A, Attachment III, Subsection 1.3.6 (*Treatment of Overpayment Recoveries*) and 42 Code of Federal Regulations (CFR) section 438.608(d)(2);

20) Confirmation of Network Provider's right to all protections afforded them under the Health Care Providers' Bill of Rights, including, but not limited to Network Provider's right to access Contractor's

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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

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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;

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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 ~~shall~~ **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** ~~for Medi-Cal members~~ **if the** ~~Network Provider Agreement to any~~ Safety-Net Provider ~~that~~ agrees to provide its **applicable** scope of services **under** ~~in accord with~~ 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.

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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.**

~~B~~ **3)**~~. Contractor must notify DHCS of intent to terminate a Network Provider Agreement with a Safety-Net Provider at least 60 calendar days prior to the effective date of termination unless such Provider's license has been revoked or suspended or where the health and welfare of a Member is threatened, in which event termination will be effective immediately, without DHCS prior approval, and Contractor must notify DHCS concurrently with the termination~~.
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*);

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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

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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

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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 (C**Y**SHCN). 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;

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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

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youth ages zero to 20; adults ages 21+), by race/ethnicity, and as requested by DHCS.

c) Contractor must work with DHCS and other stakeholders to analyze the relationship between the percent of spend for Primary Care services with performance of the overall delivery system. If the evidence shows that rebalancing to increase Primary Care spend improves quality or drives lower total cost of care, DHCS may set a target or floor for Primary Care spend in future requirements, and Contractor will be required to meet these targets for minimum Primary Care spend.

2) Ensure promotion of Primary Care delivery through alternative payment models

a) As specified by DHCS, Contractor must report on its Primary Care payment models using the HCP LAN APM Framework Categories.

b) As specified by DHCS, Contractor must report on an annual basis the number and percent of its contracted Primary Care clinicians paid using each HCP LAN APM Framework Category.

c) A description of Contractor's payment model for its five largest medical groups, as defined by the number of Providers, and how its Primary Care clinicians are paid. Contractor must adopt and progressively expand the percent of Primary Care clinicians paid through the HCP LAN APM Framework Categories of population-based payment (Category 4) and alternative payment models built on a fee-for-service structure such as shared savings (Category 3).

3.3.2 Capitation Arrangements

Payments by Contractor to a Network Provider on a capitation basis must be payable effective the date the Member's Enrollment is assigned to the Network Provider. Capitation Payments by Contractor to a Network Provider must be payable no later than 30 calendar days after the Member Assignment.

3.3.3 Provider Financial Incentive Program Payments

A. Contractor may compensate Providers through financial incentive program payments, so long as:

1) Financial incentive program payments to Providers are not designed to induce Providers to reduce or limit Medically Necessary Covered Services provided to a Member;

2) Financial incentive program payments comply with the requirements of All Plan Letter (APL) 19-005, where applicable; and

3) All financial incentive programs related to this Contract are reported in the form, manner, and frequency specified by DHCS.

B. Contractor may implement and maintain a physician incentive plan, as defined in 42 Code of Federal Regulations (CFR) section 422.208, so long as:

1) No specific payment is made directly or indirectly under the physician incentive plan as an inducement to reduce or limit Medically Necessary Covered Services provided to a Member; and

2) The physician incentive plan complies with the requirements of 42 CFR sections 438.3(i) and 438.10(f)(3).

3.3.4 Identification of Responsible Payor

Contractor must provide information to the DHCS fiscal intermediary that identifies the payor(s) responsible for reimbursement of Covered Services provided to a Member. Contractor must identify the Network Provider, Subcontractor, or Downstream Subcontractor responsible for payment, if applicable, and the name and telephone number of the Provider responsible for providing care. Contractor must provide this information upon DHCS' request and in a manner prescribed by DHCS.

3.3.5 Claims Processing

Contractor must pay all Clean Claims submitted by Providers in accordance with this section, unless the Provider and Contractor have agreed in writing to an alternate payment schedule, subject to the following:

A. Contractor must comply with 42 United States Code (USC) section 1396u-2(f) and Health and Safety Code (H&S) sections 1371 - 1371.36 and their implementing regulations. Contractor must be subject to any penalties and

sanctions, including interest at the rate of 15 percent per annum, provided by law if Contractor fails to meet the standards specified in this section.

B. Contractor is expected to pay Clean Claims within 30 calendar days of receipt. For the purpose of establishing compliance thresholds, Contractor must pay at least 90 percent of all Clean Claims from Providers within 30 calendar days of the date of receipt and 99 percent of all Clean Claims within 90 calendar days. For purposes of calculation, the date of receipt is considered the date Contractor receives the claim, as indicated by its date stamp on the claim, and the date of payment is considered be the date of the check or other form of payment. Pursuant to H&S section 1371(a), if Contractor does not pay a Clean Claim within 45 Working Days of receipt, it will owe the Provider interest at the rate of 15 percent per annum beginning on the first day after a 45 Working Day period. For the purposes of calculating interest, the first day is considered to be the first calendar day after 45 Working Days following the receipt of the claim. Contractor must automatically include all accrued interest in any late payment.

C. Contractor must provide direct instruction, training, and technical assistance to its providers to support information transmission and the submission of Clean Claims, including bills or invoices submitted by ECM providers; Community Support providers; Doulas, or other community-based providers that are unable to submit claims through an electronic file format. Contractor must make claiming, billing or invoicing guides and notices readily available to its Providers, including through Provider portals and/or Provider manuals. Contractor is ~~are~~ required to train Network Providers to effectively use electronic systems to facilitate timely submission of Clean Claims, equivalent encounters, or bills or invoices.

D. If claims are denied, rejected, or contested in whole or in part, Contractor must specify the reason(s) for contesting or denying a claim and specify the additional information necessary to complete the claim as well as offering technical assistance to remediate deficiencies.

E. Contractor must maintain procedures for pre-payment and post-payment claims review, including review of any data associated with Providers, Members, and the Covered Services for which payment is claimed.

F. Contractor must maintain sufficient claims processing, tracking, and payment systems capability to comply with applicable State and federal law, regulations, and Contract requirements, to determine the status of received claims and to provide an Incurred 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

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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.

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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.

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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

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prohibition applies to non-emergent services furnished by a Provider at the medical direction or prescribed by an Excluded Provider when the Provider knew or had a reason to know of the exclusion or prescribed by an Excluded Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of Fraud.

3.3.19 Compliance with Directed Payment Initiatives and Related Reimbursement Requirements

Contractor must reimburse eligible Providers in accordance with the terms of applicable Pass-Through Payments and Directed Payment Incentives as specified in Exhibit B, Section 1.14 (Special Contract Provisions Related to Payment). Contractor must provide Provider-level data to DHCS and Providers eligible for Directed Payment Initiatives in a form and manner specified by DHCS through APLs or other technical guidance.

Exhibit A, ATTACHMENT III

4.0 Member

DHCS is committed to ensuring that the Medi-Cal Member's experience is at the center of health care delivery from the point of Enrollment into a managed care plan throughout their time as a Member.

This Article makes explicit DHCS' commitment to a comprehensive population health managed approach that ensures all Members have equitable access to necessary wellness and prevention services, Care Coordination, Complex Care Management (CCM), Transitional Care Services, and Enhanced Care Management (ECM). From assessing the needs of Members on a population basis, to identifying and stratifying Members' risk on an individual basis, Contractors are required to have the systems (including data analytic capabilities), processes, and people (including ECM Providers in network with direct experience working with specific Populations of Focus) to support appropriate Population Health Management functions.

This Article also makes explicit DHCS' commitment to ensure that Members are appropriately accessing Covered Services, including when they are referred to community-based Providers. For example, Contractor must ensure referrals to services provided by Community Health Workers (CHWs), peer counselors, and local community organizations providing Community Support services.

This Article includes provisions that directly address Social Drivers of Health (SDOH) – from capturing and tracking SDOH data to providing Community Support services. Community Support services, such as medically tailored meals and short-term post-hospitalization services, are intended to address SDOH and can be provided by Contractors to the extent they are medically appropriate, cost-effective substitutes for Covered Services.

Finally, this Article outlines provisions related to Grievances and Appeals which includes processes by which Contractors must inform Members of their rights and ensure seamless processes by which Members can exercise their rights. DHCS also includes reporting requirements to enable DHCS to effectively monitor, oversee, and enforce Contract provisions when needed.

4.1 Marketing

4.1.1 Training and Certification of Marketing Representatives
4.1.2 Marketing Plan

4.1 Marketing

4.1.1 Training and Certification of Marketing Representatives

Before conducting any Marketing, Contractor must develop a training and certification program for Contractor's Marketing Representatives, and ensure that all staff performing any Marketing activities or distributing Marketing Materials are appropriately certified.

A. Contractor is responsible for all Marketing activities conducted on its behalf. Contractor is liable for all violations committed by any of its Marketing Representatives. Marketing staff must not provide Marketing services for more than one Contractor, and Marketing strategies must align with Contractor's efforts in improving Health Equity. Marketing Representatives must not engage in Marketing practices that illegally discriminate against a Member or Potential Member on the basis of any characteristic protected by federal or State law. Such protected characteristics include, without limitation, sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56. Contractor must ensure all Marketing activities and Marketing Materials are culturally and linguistically competent in compliance with Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*) and Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*).

B. Training Program

Contractor must develop a training program that will train staff and prepare Marketing Representatives for certification. Prior to implementation, Contractor must obtain written approval from DHCS for Contractor's training and certification program, and any changes in the program. Contractor must develop and provide to Marketing Representatives a staff orientation and Marketing Representative training/certification manual. At a minimum, the manual must explain:

1) The Medi-Cal program, including Medi-Cal Fee-For-Service (FFS), Medi-Cal managed care, Network Providers, Subcontractors, Downstream Subcontractors, and program eligibility;

2) The Medi-Cal scope of services;

3) Contractor's administrative operations and health delivery system program, including the Service Area covered, Excluded Services, additional services, conditions of Member Enrollment, and aid categories;

4) Contractor's Utilization Management policy, including, but not limited to, how Members are obligated to obtain all Non-Emergency medical care through Contractor's Network and a description of all prerequisites to medical care and other health care services, such as referrals and Prior Authorizations;

5) Contractor's Grievance and Appeals procedures; the State Hearing process; and, as applicable to Contractor's plan model, the Independent Medical Review (IMR) process;

6) When Members can disenroll from Contractor, including qualifying conditions for both voluntary and mandatory disenrollment;

7) Contractor's obligation to keep confidential any information obtained from Members and Potential Members, including information regarding eligibility under any public welfare or social services program;

8) How Contractor will supervise and monitor its Marketing Representatives and staff to ensure compliance with applicable statutes and regulations;

9) The types of acceptable and prohibited communication methods and sales techniques Marketing Representatives may or may not use;

10) Contractor's anti-discrimination policy and the prohibition against the Enrollment or failure to enroll a Member or Potential Member due to a pre-existing medical condition (except for conditions requiring Excluded Services); and

11) The consequences of Marketing misrepresentation and Abuse, including, but not limited to, discipline, suspension of Marketing activities, termination, and civil and criminal prosecution. The Marketing Representative and Contractor must understand that any Abuse of Marketing requirements can result in termination of this Contract.

4.1.2 Marketing Plan

Before conducting any Marketing, or implementing any Marketing plan, Contractor must develop and obtain DHCS written approval for its Marketing plan or changes to a Marketing plan as specified below. The Marketing plan must be specific to the Medi-Cal program only and Marketing Materials must be distributed within Contractor's entire Service Area. Contractor must ensure that the Marketing plan and all related materials are accurate and do not mislead, confuse, or defraud Members, Potential Members, or the Medi-Cal program.

A. Contractor must submit a Marketing plan to DHCS for review and approval on an annual basis and any time Contractor desires to change its Marketing plan. The Marketing plan, whether new or revised, must describe all of Contractor's current and proposed Marketing, including, but not limited to, all procedures, activities, events, and methods.

B. Contractor's Marketing plan must contain the following:

1) A table of contents section that divides the Marketing plan into chapters, sections, or pages. Each page must be dated and numbered so that chapters, sections, or pages can be easily identified and replaced when revised.

2) A mission statement or statement of purpose for the Marketing plan.

3) An organizational chart including key staff positions and the Marketing director's name, address, telephone, and facsimile number.

4) A narrative description explaining how Contractor's internal Marketing department operates by identifying key staff positions, roles, and responsibilities. The narrative must also report relationships including, if applicable, how Contractor's commercial Marketing staff and functions interface with Contractor's Medi-Cal Marketing staff and functions.

5) Copies of all Member incentives Contractor will distribute during any Marketing event or through any other Marketing activities, in accordance with All Plan Letter (APL) 16-005.

6) An explicit description of all of Contractor's expected Marketing methods and activities.

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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

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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

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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)** ~~Population Health Management Service~~
4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering
4.3.6 Screening and Assessments
4.3.7 Care Management Programs
4.3.8 Basic Population Health Management
4.3.9 Other Population Health Requirements for Children
4.3.10 Transitional Care Services
4.3.11 Targeted Case Management Services
4.3.12 Mental Health Services
4.3.13 Alcohol and Substance Use Disorder Treatment Services
4.3.14 California Children's Services
4.3.15 Services for Persons with Developmental Disabilities
4.3.16 School-Based Services
4.3.17 Dental
4.3.18 Direct Observed Therapy for Treatment of Tuberculosis
4.3.19 Women, Infants, and Children Supplemental Nutrition Program
4.3.20 Home and Community-Based Services Programs
4.3.21 In-Home Supportive Services
4.3.22 Indian Health Care Providers
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.

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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** ~~Department~~.

D. Contractor must ensure that any populations covered by a Fully Delegated Subcontractor, Partially Delegated Subcontractor, or Downstream Subcontractor are included in the PNA and PHM Strategy process.

E. Contractor must publish on its website all LHD CHAs/CHIPs in the Service Area along with a brief description of how Contractor participated in the CHA/CHIP process. Contractor must also share findings from the CHA/CHIPs in Service Area with their Community Advisory Committees (CACs).

F. Based on participation in the CHA/CHIP process in the Service Area, Contractor must annually review and update the following in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy:

1) Targeted health education materials for Members, including Member-facing outreach materials for any identified gaps in services and resources, including but not limited, to Non-Specialty Mental Health Services;

2) Cultural and linguistic and quality improvement strategies to address identified population-level health and social needs; and

3) Wellness and prevention programs.

G. Contractor's MOU with an LHD must include a requirement that Contractor coordinate with the LHD to develop a process to implement DHCS guidance regarding the PNA and PHM Strategy requirements.

H. The PNA and PHM Strategy requirements, as outlined in this Subsection, and other PHM deliverables, as described in this Contract, remain consistent with 22 CCR, sections 53876, 53851(b)(2), 53851(e), 53853(d), and 53910.5(a)(2), 28 CCR, section 1300.67.04; 42 CFR sections 438.206(c)(2), 438.330(b)(4) and 438.242(b)(2); and APL 23-021.

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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) ~~Population Health Management Service~~

Contractor must use the PHM Service in accordance with all applicable federal and State laws and regulations, and in a manner specified by DHCS. Contractor must use the PHM Service, at a minimum, to:

A. Perform Risk Stratification and Segmentation (RSS) activities and Risk Tiering functions as described in this Subsection;

B. Identify and assess Member-level risks and needs through use of the PHM Service's Risk Tiering functionality, which places Members into high, medium-rising, or low Risk Tiers, and use the RSS and Risk Tiering functionality to identify and assess Member-level risks and needs as specified in the PHM Policy Guide;

C. Inform and enable Member screening and assessment activities, including pre-populating screening and assessment tools; and

D. Support Member engagement and education activities.

4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering

A. Contractor must use RSS and Risk Tiering to identify and assess Member-level risks and needs and, as needed, connect Members to services in a manner specified in the PHM Policy Guide and detailed below:

1) Consider findings from the PNA and all Members' behavioral, developmental, physical, oral health, and Long-Term Services and Supports (LTSS) needs, as well as health risks, rising-risks, and health-related social needs due to SDOH;

2) Comply with NCQA PHM standards;

3) Risk stratify and/or segment all Members at least annually and during each of the following timeframes:

a) Upon each Member's Enrollment;

b) Annually after each Member's Enrollment;

c) Upon a Significant Change in the health status or level of care of the Member; and

d) Upon the occurrence of events or new information that Contractor determines as potentially changing a Member's needs, including but not limited to, referrals for Complex Care Management (CCM), Enhanced Care Management (ECM), and Transitional Care Services.

4) Submit its processes to DHCS upon request regarding how it identifies Significant Changes in Members' health status or level of care and how it is monitoring appropriate re-stratification;

5) Incorporate a minimum list of data sources, as specified in the PHM Policy Guide;

6) Avoid and reduce biases in its RSS approach, such as only using utilization data, by using evidence-based methods to prevent further exacerbation of Health Disparities; and

7) Continuously reassess the effectiveness of the RSS methodologies and tools.

B. Once the PHM Service RSS and Risk Tiering functionality is available for use by Contractor, Contractor must use RSS and PHM Service Risk Tiers to:

1) Connect all Members, including those with rising risk, to an appropriate and available Contractor-identified level of service, including but not limited to, care management programs, Basic PHM, and Transitional Care Services; and

2) Contractor may supplement the PHM Service outputs with local data sources and methodologies.

C. Upon request, Contractor must ensure that its RSS and Risk Tiering approach is submitted to DHCS for review and approval in a form and method prescribed by DHCS.

4.3.6 Screening and Assessments

A. In accordance with 42 CFR section 438.208, Contractor must conduct an initial screening or assessment of each Member's needs within 90 days of Enrollment and share that information with DHCS, and other managed care health plans or Providers serving the Member, to prevent duplication of those activities. Contractor must make at least three attempts to contact a Member to conduct the initial screening or assessment using available modalities.

B. Contractor must conduct necessary screening and assessments to gain timely information on the health and social needs of all Members, in accordance with applicable State and federal laws and regulations, and NCQA PHM standards.

C. Contractor must abide by DHCS guidance for Member screening and assessment, including guidance for how to use the PHM Service for the screening and assessment process.

D. Contractor must monitor what percentage of required assessments are completed per the specifications above.

4.3.7 Care Management Programs

Contractor must maintain a PHM delivery infrastructure to ensure that the needs of its entire Member population are met across the continuum of care. The infrastructure must provide Members with the appropriate level of care management through person-centered interventions based on the intensity of health and social needs and services required. The care management interventions described in this Subsection are intended for specific segments of the population that require more intensive engagement than the Basic PHM described in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*). Members receiving the care management services described in this Subsection must have an assigned CCM Care Manager and a Care Management Plan (CMP).

Enhanced Care Management

Enhanced Care Management (ECM) is a whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high need and/or high-cost Members**.** ECM provides 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,

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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~~.~~**; and**

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:

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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;

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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

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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

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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

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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 C**Y**SHCN.

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

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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

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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.

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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~~.~~**; and**

   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;

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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~~.~~;

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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:

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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

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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; ~~Identify~~ **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*

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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

   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.

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
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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.

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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

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condition of entering into a Subcontractor Agreement or Network Provider Agreement, as appropriate.

J. Contractor must ensure ECM Providers serving the Justice Involved Population of Focus meet not only the standard ECM Provider requirements, but requirements outlined in the JI Policy and Operational Guide for Planning and Implementing the Justice Involved Initiative, including, but not limited to:

1) Meeting the following criteria pertaining to participation in pre-release care management services and warm handoffs:

a) If the Correctional Facilities in the ECM Provider's county of operation leverage an in-reach care management model, Contractor must ensure that JI ECM Providers offer pre-release care management services as in-reach care management Providers and continue to serve the Member post-release as the Member's ECM Provider.

b) If the Correctional Facilities in the ECM Provider's county of operation leverage an embedded care management model, Contractor must ensure that the ECM Provider participates in a warm handoff with the pre-release embedded care manager and the Member.

2) ECM Providers must bill Fee-for-Service (FFS) for all pre-release care management services and warm handoffs by either enrolling through the Provider Application and Validation for Enrollment (PAVE) system or contracting with the Correctional Facility to provide services billed under the Correctional Facility National Provider Identifier (NPI).

4.4.4 Enhanced Care Management Provider Capacity

A. Contractor must develop and manage a network of ECM Providers.

B. Contractor must ensure sufficient ECM Provider capacity to meet the unique needs of all ECM Populations of Focus, including by contracting with providers with specific skills and experience serving specific Populations of Focus.

C. Contractor must meet DHCS' requirements regarding ECM Provider capacity separately from general Network adequacy; ECM Provider

capacity does not alter the general Network adequacy provisions in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*).

D. Contractor must report on its ECM Provider capacity to DHCS initially in its ECM Model of Care (MOC) Template as referenced in Exhibit A, Attachment III, Subsection 4.4.*5 (Enhanced Care Management Model of Care)* and on an ongoing basis pursuant to DHCS reporting requirements in a form and manner specified by DHCS.

E. Contractor must report to DHCS any Significant Changes in its ECM Provider capacity as soon as possible but no later than 60 days from the occurrence of the change, in accordance with DHCS reporting requirements in a form and manner specified by DHCS.

F. If Contractor is unable to provide sufficient capacity to meet the needs of all ECM Populations of Focus through Subcontractor or Network Provider Agreements, as appropriate, with community-based ECM Providers, Contractor may submit a written request to DHCS for an exception that authorizes Contractor to use its own personnel for ECM. Any such request must be submitted in accordance with DHCS guidelines and must meet at least one of the following criteria:

1) There are insufficient ECM Providers, or a lack of ECM Providers with qualifications and experience, to provide ECM for one or more of the Populations of Focus in one or more counties;

2) There is a justified Quality of Care concern with one or more of the otherwise qualified ECM Providers;

3) Contractor and the ECM Providers are unable to agree on rates;

4) ECM Providers are unwilling to contract;

5) ECM Providers are unresponsive to multiple attempts to contract;

6) ECM Providers who have a State-level pathway to Medi-Cal Enrollment but are unable to comply with the Medi-Cal Enrollment process or Contractor's verification requirements for ECM Providers; or

7) ECM Providers without a State-level pathway to Medi-Cal Enrollment that are unable to comply with Contractor's verification requirements for ECM Providers.

G. During an exception period approved by DHCS, Contractor must take steps to continually develop and increase its ECM Network capacity. After the expiration of an exception period, Contractor must submit a new exception request to DHCS for DHCS review and approval on a case-by-case basis.

H. Contractor's failure to provide network capacity that meets the needs of all ECM Populations of Focus in a community-based manner may result in imposition of Corrective Action proceedings, and may result in sanctions pursuant to Exhibit E, Section 1.19 (*Sanctions*).

I. Contractor must ensure Network overlap of the Justice Involved pre-release care management Provider network and the Justice Involved ECM Provider network across Contractor's Service Area. Contractor must submit to DHCS, for prior approval, any requests for exception from Network overlap requirements across Medi-Cal managed care plans in the same county for one of the permissible reasons as described in the JI Policy and Operational Guide for Planning and Implementing the Justice Involved Initiative.

4.4.5 Enhanced Care Management Model of Care

A. Contractor must develop an ECM MOC template in accordance with the DHCS-approved MOC Template. The MOC must specify Contractor's framework for providing ECM, including a listing of its ECM Providers and policies and procedures for partnering with ECM Providers for the provision of ECM.

B. In developing and executing Subcontractor Agreements or Network Provider Agreements, as appropriate, with ECM Providers, Contractor must incorporate all requirements and policies and procedures described in its MOC, in addition to APLs.

C. Contractor may collaborate with other Medi-Cal managed care health plans within the same county on the development of its MOC as applicable for Contractor's plan model.

D. Contractor must submit its ECM MOC for DHCS review and approval. Contractor must also submit to DHCS any Significant Changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs. Significant Changes may include, but are not limited to, changes to Contractor's approach to administering or delivering ECM services, approved policies and procedures, and

Subcontractor Agreement and Downstream Subcontractor Agreement boilerplates.

4.4.6 Member Identification for Enhanced Care Management

A. Contractor must proactively identify Members who may benefit from ECM and who meet the eligibility criteria for the ECM Populations of Focus, as described in Exhibit A, Attachment III, Subsection 4.4.2 (*Populations of Focus for Enhanced Care Management*).

B. To identify such Members, Contractor must consider the following:

1) Members' health care utilization;

2) Needs across physical, behavioral, developmental, and oral health;

3) Health risks and needs due to Social Drivers of Health; and,

4) Long-Term Services and Supports needs.

C. Contractor must identify Members for ECM through the following pathways:

1) Analysis of Contractor's own enrollment, claims, and other relevant data and available information. Contractor must use data analytics to identify Members who may benefit from ECM and who meet the criteria for the ECM Populations of Focus. Contractor must consider data sources, including but not limited to:

a) Enrollment data;

b) Encounter Data;

c) Utilization/claims data;

d) Pharmacy data;

e) Laboratory data;

f) Screening or assessment data;

g) Clinical information on physical and Behavioral Health;

h) SMI/SED/SUD data, if available;

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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

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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.

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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;

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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

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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 Federal 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~~, as indicated in the DHCS guidance on eligible populations incorporated in the Community Supports Policy Guide~~.

2) Contractor may not adopt a more narrowly defined eligible population for Community Supports than outlined **in** ~~in the Community Supports Policy Guide.~~ **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 ~~who may benefit from Community Supports~~ ~~and~~ for whom Community Supports will be a medically appropriate **alternative to** ~~and cost-effective substitute for~~ Covered Services, and accept requests for Community Supports from Members and Members' Providers and organizations that serve them, including community-based organizations as described in Exhibit A, Attachment III, Subsection 4.5.6 (*Identifying Members for Community Supports*).

F. Contractor must authorize Community Supports for Members deemed eligible in accordance with Exhibit A, Attachment III, Subsection 4.5.7

(*Authorizing Members for Community Supports and Communication of Authorization Status*).

G. Contractor may elect to offer value-added services in addition to offering one or more Community Supports. Offering or not offering Community Supports does not preclude Contractor from offering value-added services.

H. In the event of any discontinuation of Community Supports resulting in a change in the availability of services, Contractor must adhere to the requirements set forth in Exhibit A, Attachment III, Subsection 5.2.9 (*Network and Access Changes to Covered Services*).

I. When Members are dually eligible for Medicare and Medi-Cal, and enrolled in a Medicare Advantage Plan, including a Dual Special Needs Plan (D-SNP), Contractor must coordinate with the Medicare Advantage Plan in the provision of Community Supports.

J. Contractor must not require Members to use Community Supports.

4.5.2 DHCS Pre-Approved Community Supports

A. Contractor may choose to offer Members one or more of the following pre-approved Community Supports, and any subsequent Community Supports additions pre-approved by DHCS, in each county.

1) Housing transition navigation services~~;~~

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):

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a. Have disabilities;

b. Have one or more serious chronic conditions;

c. Have a Serious Mental Illness (SMI);

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~~;~~

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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**

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 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 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;

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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

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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 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**

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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**

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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 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~~; and~~

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 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~~.~~

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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).

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4.5.3 Community Supports Providers

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

B. Contractor must enter into Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers for the delivery of Community Supports elected by Contractor.

C. Contractor must ensure all Community Supports Providers for whom a State-level Enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 22-013. If APL 22-013 does not apply to a Community Supports Provider, Contractor must have a process for verifying qualifications and experience of Community Supports Providers, which must extend to individuals employed by or delivering services on behalf of the Community Supports Provider. Contractor must ensure that all Community Supports Providers meet the capabilities and standards required to be a Community Supports Provider.

D. In accordance with Exhibit A, Attachment III, Subsection 4.5.9 (*Data System Requirements and Data Sharing to Support Community Supports*), Contractor must support Community Supports Provider access to systems and processes allowing them to do the following, at a minimum:

   1) Obtain and document Member Information including eligibility, Community Supports authorization status, Member authorization for data sharing (to the extent required by law), and other relevant demographic and administrative information; and

   2) Support Community Supports Provider notification to Contractor, ECM Providers, and Member's Primary Care Provider (PCP), as applicable, when a referral has been fulfilled, as described in Exhibit A, Attachment III, Subsection 4.5.9 (*Data System Requirements and Data Sharing to Support Community Supports*).

E. To the extent Contractor elects to offer Community Supports, Contractor may coordinate its approach with other Medi-Cal managed care health plans offering Community Supports in the same county.

F. Contractor must prioritize contracting with locally available community-based organizations that have experience working with eligible populations and delivering the outlined Community Supports services (e.g., Supportive housing providers, Skilled Nursing Facilities (SNFs), medically tailored meals providers).

4.5.4 Community Supports Provider Capacity

A. Contractor must develop a robust network of Community Supports Providers to deliver all elected Community Supports.

B. If Contractor is unable to offer its elected Community Supports to all eligible Members for whom it is medically appropriate and cost-effective within a particular county, Contractor must submit ongoing progress reports to DHCS in a format and manner specified by DHCS.

C. Contractor must ensure all of its Community Supports Providers have sufficient capacity to receive referrals for Community Supports and provide the agreed-upon volume of Community Supports to Members who are authorized for such services on an ongoing basis.

4.5.5 Community Supports Model of Care

A. Contractor must develop a Community Supports MOC in accordance with the DHCS-approved Community Supports MOC template. The Community Supports MOC must specify Contractor's framework for providing Community Supports, including a listing of its Community Supports Providers and policies and procedures for partnering with Community Supports Providers for the provision of Community Supports.

B. In developing and executing Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers, Contractor must incorporate all requirements and policies and procedures described in its Community Supports MOC, in addition to APLs.

C. Contractor may collaborate with other Medi-Cal managed care health plans within the same county on the development of its Community Supports MOC.

D. Contractor must submit its Community Supports MOC for DHCS review and approval. Contractor must also submit to DHCS any significant changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any such occurrence of changes

or updates, in accordance with DHCS policies and guidance, including APLs. Significant changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services; approved policies and procedures; and Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement boilerplates, as appropriate.

4.5.6 Identifying Members for Community Supports

A. Contractor must utilize a variety of methods to identify Members who may benefit from Community Supports, in accordance with all applicable DCHS APLs.

B. Contractor must develop policies and procedures for Community Supports, and submit its policies and procedures to DHCS for review and approval prior to implementation. Contractor's policies and procedures must address the following, at a minimum:

1) How Contractor will identify Members eligible for Community Supports;

2) How Contractor will notify Members; and

3) How Contractor will receive requests to evaluate Members for Community Supports from Providers; community-based entities; and Member or Member's family, legal guardians, Authorized Representatives (ARs), and caregivers.

C. Contractor must submit all Member notices to DHCS for review and approval prior to implementation.

D. Contractor must ensure that Member identification methods for Community Supports are equitable and do not exacerbate or contribute to existing racial and ethnic disparities.

4.5.7 Authorizing Members for Community Supports and Communication of Authorization Status

A. Contractor must develop and maintain policies and procedures that explain how Contractor will authorize Community Supports for eligible Members in an equitable and non-discriminatory manner. Contractor must submit its policies and procedures to DHCS for review and approval prior to implementation.

1) Contractor's policies and procedures must include a framework for considering medical appropriateness in relation to Contractor's proposed approach for providing Community Supports.

2) Each Community Support authorization request must be considered separately for a Member. Contractor must evaluate each authorization request for medical appropriateness. Receiving one Community Support does not preclude a ~~m~~**M**ember from being authorized for additional Community Supports unless a conflict is specified by DHCS.

B. Contractor must monitor and evaluate Community Supports authorizations to ensure they are equitable and non-discriminatory. Contractor must have policies and procedures in place for immediate actions that it will undertake if monitoring/evaluation processes reveal that service authorizations have had an inequitable effect.

C. ~~For Members with an assessed risk of incurring other California Medicaid State Plan services, such as inpatient hospitalizations, Skilled Nursing Facility (SNF) stays, or emergency department visits, Contractor must develop policies and procedures to ensure appropriate clinical support authorization of Community Supports for Members.~~ Contractor's policies and procedures must include detailed documentation that a Network Provider**, 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

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regarding Community Supports authorization, in accordance with APLs. If the Member is enrolled in ECM, Contractor must ensure the ECM Provider is informed of the Community Supports authorization decision.

G. Members always retain the right to file Appeals and/or Grievances if they request one or more Community Supports offered by Contractor but were not authorized to receive the requested Community Supports ~~because of a determination that it was not medically appropriate or cost-effective~~.

H. For Members who sought Community Supports offered by Contractor, but were not authorized to receive the Community Supports, Contractor must submit necessary data to monitor Appeals and Grievances as well as follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011.

4.5.8 Referring Members to Community Supports Providers for Community Supports

A. Contractor must develop and maintain policies and procedures to define how Community Supports Provider referrals will occur. Contractor must submit to DHCS policies and procedures for review and approval prior to implementation.

1) For Members enrolled in ECM, Contractor's policies and procedures must address how Contractor will work with the ECM Provider to coordinate the Community Supports referral and communicate the outcome of the referral back to the ECM Provider.

2) Contractor's policies and procedures must include expectations and procedures to ensure referrals occur in a timely manner after service authorization.

B. If the Member prefers a particular Community Supports Provider and Contractor is aware of this preference, Contractor must follow those preferences, to the extent practicable.

C. Contractor must track referrals to Community Supports Providers to verify if the authorized service has been delivered to the Member.

If the Member receiving Community Supports is also receiving ECM, Contractor must monitor to ensure that the ECM Provider tracks whether the Member receives the authorized service from the Community Supports Provider.

D. Contractor must not require Member authorization for Community Supports-related data sharing as a condition of initiating delivery of Community Supports, unless such authorization is required by State or federal law.

E. Contractor must develop and maintain policies and procedures for its network of Community Supports Providers to:

1) Ensure the Member agrees to receive Community Supports;

2) Where required by applicable law, ensure that Members authorize information sharing with Contractor and all others involved in the Member's care as needed to support the Member and maximize the benefits of Community Supports, in accordance with APLs, laws, and regulations;

3) Provide Contractor with Member-level records of any obtained authorization for Community Supports-related data sharing which are required by law, and to facilitate ongoing data sharing with Contractor; and

4) Obtain Member authorization to communicate electronically with the Member, Member's family, legal guardians, ARs, caregivers, and other authorized support persons, if Contractor intends to do so.

4.5.9 Data System Requirements and Data Sharing to Support Community Supports

A. Contractor must use systems and processes capable of tracking Community Supports referrals, access to Community Supports, and Grievances and Appeals.

Contractor must support Community Supports Provider access to systems and processes allowing them to track and manage referrals for Community Supports and Member information.

B. Consistent with federal, State and, if applicable, local privacy and confidentiality laws, Contractor must ensure Community Supports Providers have access to the below as part of the referral process to Community Supports Providers:

1) Demographic and administrative information confirming the referred Member's eligibility and authorization for the requested service;

2) Appropriate administrative, clinical, and social service information that Community Supports Providers might need to effectively provide the requested service; and

3) Billing information necessary to support the Community Supports Providers' ability to submit claims or invoices to Contractor.

C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS in compliance with data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with H&S section 130290, when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.

4.5.10 Contractor's Oversight of Community Supports Providers

A. Contractor must comply with all State and federal reporting requirements.

B. Contractor must perform oversight of Community Supports Providers, holding them accountable for all Community Supports requirements contained in this Contract~~,~~ and **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.

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**.**~~, in accordance with APLs.~~

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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.

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.

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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

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Subcontractors are trained on and immediately notified of any changes to Contractor's Grievance and Appeal policies and procedures.

J. Maintains policies and procedures for compiling, aggregating, and reviewing Grievance and Appeal data for use in Contractor's Quality Improvement Strategy (QIS). Contractor must regularly analyze Grievance and Appeal data to identify, investigate, report, and act upon systemic patterns of improper service denials and other trends impacting health care access and delivery to Members. Contractor must impose necessary Corrective Action to remedy all identified deficiencies.

K. Maintains records of Grievances and Appeals in a manner accessible to DHCS and to the Centers for Medicare & Medicaid Services (CMS), upon request. Contractor must review Grievance and Appeal data and information as part of its ongoing monitoring procedures as well as for updates and revisions to its QIS. The record of each Grievance or Appeal must contain, at a minimum, all information set forth in 42 CFR section 438.416(b). Contractor must ensure that all documents and records, whether in written or electronic format, generated or obtained by Contractor in the course of responding to Adverse Benefit Determinations (ABD), Grievances, Appeals, and Independent Medical Reviews (IMRs) are retained for at least 10 years pursuant to 42 CFR section 438.3(u).

4.6.2 Grievance Process

Contractor's policies and procedures must include all required information set forth below for Grievances and the expedited review of Grievances as required under 42 CFR sections 438.402, 438.406, and 438.408; 28 CCR sections 1300.68 and 1300.68.01; and 22 CCR section 53858:

A. A policy and procedure for Members to file a Grievance with Contractor at any time to express dissatisfaction about any matter other than a notice of ABD.

B. A policy and procedure to allow Members to file a Grievance to contest Contractor's unilateral decision to extend the timeframe for resolution of an Appeal or expedited Appeal.

C. A policy and procedure to ensure that every Grievance involving clinical issues that is submitted is reported to qualified medical professionals with appropriate clinical expertise and is escalated to Contractor's medical director as needed, to ensure the Grievance is properly handled.

D. A policy and procedure to ensure that Contractor's staff monitor Grievances to identify issues that require Corrective Action. Grievances related to medical Quality of Care issues must be referred to qualified medical professionals with appropriate clinical expertise and be escalated to Contractor's medical director as needed.

E. A policy and procedure for Contractor to provide written acknowledgement to the Member within five calendar days of receipt of the Grievance. The acknowledgement letter must advise the Member that the Grievance has been received; provide the date of receipt; and provide the name, telephone number, and address of the representative who the Member, their Provider, or their AR may contact about the Grievance.

4.6.3 Discrimination Grievances

Contractor must process Discrimination Grievances as required by federal and State nondiscrimination law and DHCS policy, as stated in 45 CFR section 84.7, 34 CFR section 106.8, 28 CFR section 35.107, W&I section 14029.91(e)(4), and APL 21-004.

A. Contractor must designate a Discrimination Grievance coordinator responsible for ensuring compliance with federal and State nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or State nondiscrimination law.

B. Contractor must adopt and implement written policies and procedures to ensure the prompt and equitable resolution of Discrimination Grievances. Contractor must not require a Member or Potential Member to file a Discrimination Grievance with Contractor before filing with the DHCS Office of Civil Rights or the U.S. Department of Health and Human Services Office for Civil Rights.

C. Within ten calendar days of mailing a Discrimination Grievance resolution letter, Contractor must submit information regarding the Discrimination Grievance to the DHCS Office of Civil Rights, as specified in APL 21-004.

D. Contractor must inform Members on its website that Discrimination Grievances may be filed directly with the DHCS Office of Civil Rights and must include contact information for the DHCS Office of Civil Rights, as required by Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*).

4.6.4 Notice of Action

When Contractor makes an authorization decision, it must send a Notice of Action (NOA). A NOA is a notice of any action that impacts a Member's ability to obtain Covered Services or other benefits Contractor is required to provide under this Contract. A NOA includes, but is not limited to, a notice of ABD for a requested health care service under 42 CFR sections 438.210(d) and 438.404, including requested Community Supports that Contractor has elected to cover under 42 CFR section 438.3(e)(2).

Contractor's failure to render a decision and send a written NOA to the Member within the required timeframes below is considered a denial of the requested service and therefore constitutes an ABD on the date that Contractor's timeframe for approval expires, in accordance with 42 CFR section 438.404(c)(5). In cases where Contractor fails to meet the required notice timeframes, the Member may immediately request an Appeal with Contractor and Contractor must send the Member written notice of all Appeal rights.

A. Standard Authorization Requests

1) Contractor must ensure a NOA is sent when approving, denying or modifying a Provider's Prior Authorization or concurrent request for health care services (excluding pharmacy services, but including Community Supports) for a Member within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than five Working Days from Contractor's receipt of information reasonably necessary and requested by Contractor to make a determination, not to exceed 14 calendar days following Contractor's receipt of the request for service, in accordance with 42 CFR sections 438.210(d)(1) and 438.404(c)(3); and

2) Contractor must notify the requesting Provider of its authorization decision within 24 hours of the decision and send the written NOA to the Member within two Working Days in accordance with H&S section 1367.01(h)(1) and (3).

3) Contractor must send the written NOA approving, denying, or modifying the authorization request. Contractor must approve, deny, or modify the request and send the written NOA within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than five Working Days from Contractor's receipt of information reasonably necessary and requested by Contractor to make a determination, not to exceed 14

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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;

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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

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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

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date it reverses the action if the disputed services were not provided during the Appeal.

E. Contractor must pay for disputed services if the Member received the disputed services while the Appeal was pending.

F. Contractor must provide the Member or AR the opportunity before and during their Appeal process to examine their case file. Contractor must provide, sufficiently in advance of the resolution timeframe and free of charge, the Member's case file, including Medical Records, clinical criteria, guidelines, and all documents and records Contractor relied on during the Appeal process for its decision. Contractor must assist any Member who requires assistance preparing their Appeal.

G. Contractor may withdraw a Grievance or Appeal upon Member request if performed in compliance with the established Grievance and Appeals processes required in this Contract and federal and State laws and regulations. Where a Grievance or Appeal was filed by a Provider or AR of a Member, written Member consent is required for a Provider or AR to withdraw the Grievance or Appeal.

4.6.6 Responsibilities in Expedited Appeals

Contractor must implement and maintain policies and procedures as described below to resolve expedited Appeals. Contractor must follow the expedited Appeal process when it determines or the requesting Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life; physical or mental health; or ability to attain, maintain, or regain maximum function.

A. A Member, or a Provider or an AR with the Member's written consent, may file an expedited Appeal either orally or in writing. No additional follow-up from the Member is required. Contractor must ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's Appeal.

B. Contractor must inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person, by phone, or in writing, sufficiently in advance of the resolution timeframe.

C. Contractor must resolve an expedited Appeal as quickly as the Member's health condition requires, but no later than 72 hours from the day Contractor receives the request for an expedited Appeal.

D. Contractor must make a reasonable effort to provide oral notice of an expedited Appeal decision.

E. If Contractor denies a request for an expedited resolution of an Appeal, it must process the request for an Appeal in accordance with the standard Appeal process timeframes for resolutions and extensions as required in Exhibit A, Attachment III, Subsection 4.6.5 (*Appeal Process*).

4.6.7 State Hearings and Independent Medical Reviews

A. State Hearings

1) The Member, or a Provider or AR with the Member's written consent, may request a State Hearing:

a) After receiving a NAR confirming that Contractor has upheld its ABD, and the request is made within 120 calendar days from the date on the NAR;

b) In cases of Deemed Exhaustion, due to Contractor's failure to comply with Appeal notice and timing requirements as required by 42 CFR sections 438.10, 438.402, 438.404, 438.406, 438.408, and 438.410; W&I sections 10951 and 10951.5; and as stated in this Contract, the Member may immediately request a State Hearing. In cases of Deemed Exhaustion, Contractor must not request a dismissal of the State Hearing based on a failure to exhaust Contractor's internal Appeal process; or

c) If Contractor fails to provide Appeal notices required in 42 CFR section 438.408 to a Member with a visual impairment, in the Member's selected alternative format and within the applicable federal or State timeframes, the Member is deemed to have exhausted Contractor's internal Appeal process and may immediately request a State Hearing. In such cases, Contractor is prohibited from requesting dismissal of a State Hearing on the basis of failure to exhaust Contractor's internal Appeal process.

2) Upon request from the Member, Contractor must assist the Member with preparing for the State Hearing by providing the Member or their AR with the Member's case file, including Medical Records, other documents and records, guidelines, clinical criteria, and any new or additional evidence that Contractor relied on for its

initial denial and anything Contractor considered during its internal Appeal process. This information must be provided free of charge and sufficiently in advance of the resolution timeframe.

3) Contractor must provide its statement of position for the State Hearing to the Member and to the California Department of Social Services at least two Working Days before the State Hearing.

4) Contractor must ensure that an employee familiar with the facts of the case and Contractor's basis for upholding its ABD is available to actively participate in the State Hearing by ensuring that the employee is available and prepared to present Contractor's position and be subject to cross examination at the State Hearing as required by 42 CFR sections 431.205 and 431.242 and *Goldberg v. Kelly* (1970) 397 US 254. Contractor must ensure that it provides accurate contact information for its State Hearing representative to ensure an appearance at the State Hearing via telephone or in person. Additionally, to ensure Member's right to due process during the State Hearing process, Contractor must ensure that a statement of position is timely filed with the California Department of Social Services and provided to the Member not less than two Working Days before the hearing as required by W&I section 10952.5.

5) In cases where the State Hearing decision overturns Contractor's decision, Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date Contractor receives notice that the State Hearing decision reversed Contractor's decision.

6) Contractor must pay for disputed services if the Member received the disputed services while the State Hearing was pending.

7) The parties to a State Hearing must include Contractor as well as the Member, their AR, or the representative of a deceased Member's estate.

8) Contractor must notify Members that the State must make a decision for a State Hearing within 90 calendar days of the date of the State Hearing request. For an expedited State Hearing, DHCS will take final administrative action as expeditiously as the individual's health condition requires, but no later than three Working Days after Contractor provides DHCS with the case file

and information supporting its Appeal of an ABD pursuant to W&I section 10951.5. Contractor must also comply with all other requirements as required by 42 CFR sections 438.410 and 438.404(a), W&I section 14029.91(e), 22 CCR sections 53876 and 53895, and APL 21-011.

B. Contractor's Obligations for Expedited State Hearings

1) Within two Working Days of being notified by DHCS or the California Department of Social Services that a Member has filed a request for State Hearing which meets the criteria for expedited resolution, Contractor must deliver directly to the designated/appropriate California Department of Social Services administrative law judge all information and documents which either support, or which Contractor considered in connection with, the action which is the subject of the expedited State Hearing. This includes, but is not limited to, copies of the relevant Treatment Authorization Request and NOA, plus any pertinent NAR and all documents Contractor relied on for its denial, including clinical criteria and guidelines. If the NOA or NARs are not in English, Contractor must transmit fully translated copies to the California Department of Social Services along with copies of the original NOA and NARs.

2) Contractor must ensure that an employee familiar with the facts of the case and Contractor's basis for upholding its ABD is available to actively participate in the expedited State Hearing by ensuring that the employee is available and prepared to present Contractor's position during cross examination at the State Hearing as required by 42 CFR sections 431.205 and 431.242 and *Goldberg v. Kelly* (1970) 397 US 254. Contractor must ensure that it provides accurate contact information for its State Hearing representative to ensure an appearance at the Hearing via telephone or in person. Additionally, to ensure Member's right to due process during the State Hearing process, Contractor must ensure that its completed case file, including the statement of position, is timely filed with the California Department of Social Services as required by W&I section 10951.5(b)(1).

C. Independent Medical Review

1) If applicable to Contractor's plan model, Contractor must inform Members of the right to request an IMR of an action resulting in a Member request for an Appeal, or the outcome of an Appeal.

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2) An IMR must be requested by the Member, or a Provider or AR with written authorization from the Member to act on the Member's behalf. Contractor must not require a Member to request an IMR before, or use one as a deterrent to, requesting a State Hearing.

3) IMRs must be conducted by the California Department of Managed Healthcare (DMHC) independently from either the Member or Contractor, and at no cost to the Member.

4) IMRs do not extend any of the time frames stated in this Contract for Appeals, and do not disrupt the continuation of Covered Services per 42 CFR section 438.420.

4.6.8 Continuation of Services Until Appeal and State Hearing Rights Are Exhausted

A. Contractor must automatically continue providing the disputed services to the Member while the Appeal and State Hearing are pending if all of the following conditions are met:

1) The Member filed their Appeal within the required timeframes set forth in 42 CFR section 438.420;

2) The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

3) The disputed services were ordered by the Member's Provider; and

4) The period covered by the original authorization has not expired.

B. If Contractor, at the Member's request, continues or reinstates the provision of disputed services while an Appeal or State Hearing is pending, those services must continue until:

1) The Member withdraws their request for an Appeal or a State Hearing;

2) The Member fails to request a State Hearing and continuation of disputed services within ten calendar days of when the NOA was sent; or

3) The final State Hearing decision is adverse to the Member.

C. Contractor must pay for disputed services if the Member received the disputed services while the Appeal or State Hearing was pending. Contractor must ensure the Member is not billed for the continued services even if the State Hearing or IMR finds the disputed services were not Medically Necessary.

4.6.9 Grievance and Appeal Reporting and Data

A. Contractor must submit ~~to DHCS~~ a ~~monthly~~ Grievance and Appeal ~~report~~ **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.~~B~~. Contractor must comply with the requirements set forth in Exhibit A, Attachment III, Section 2.1 (*Management Information System*) of this Contract for the reporting of Grievance and Appeal data.

D.~~C~~. Contractor must maintain records of Grievances and Appeals and must have policies and procedures in place governing the review of the information as part of its ongoing QIS. Contractor must identify systemic patterns of wrongful denials and impose Corrective Action as necessary. The records must be accurately maintained in a manner accessible to the State and available to CMS upon request. Records must include all required information set forth in 42 CFR section 438.416(b). Contractor must ensure that all documents and records, whether in a written or electronic format, generated or obtained by Contractor in the course of responding to ABDs, Grievances, Appeals, and IMRs are retained for at least 10 years pursuant to 42 CFR section 438.3(u).

Exhibit A, ATTACHMENT III

5.0 Services – Scope and Delivery

DHCS has a longstanding commitment to ensure Members have access to high-quality services. The provisions in this Article lay out DHCS expectations of Contractor for promoting access to medical, behavioral, and social services; increasing integration and collaboration across delivery systems and with local partners; and ultimately improving health outcomes.

Through the provisions in this Article, several key goals of California Advancing and Innovating Medi-Cal (CalAIM) are addressed. For example, Contractor must manage the health care needs of the Member over time through a comprehensive array of person-centered health and social services spanning all levels of intensity of care, from birth to dignified end of life. This Article also includes provisions related to Advance Directives and ensuring that Contractor informs Members of what an Advance Directive is and how to put a valid one in place. This Article contains key provisions related to information Members must receive to help them navigate the health care system including information that must be included in the Member Handbook and Provider Directory.

This Article also address access to evidence-based Behavioral Health care, with a focus on integration with physician health and earlier identification and engagement in treatment for Children, youth, and adults. Provisions included here also implement No Wrong Door policies and outline expectations that Contractor ensure Members receive timely mental health services without delay regardless of the delivery system where they seek care. Contractors are expected to ensure Members maintain treatment relationships with trusted Providers without interruption, to the extent feasible.

This Article lays out expectations for services and access to community-based Providers that provide social support including Dyadic Care Services, Doula services, and Community Health Workers (CHW). The intent for enabling access to these provider types is to improve health outcomes by meeting the Behavioral Health (including emotional health and wellbeing), and physical health needs of culturally diverse populations.

DHCS recognizes the importance of coordination and collaboration with other local partners in order to meet the needs of the whole person. Accordingly, DHCS sets forth requirements for Contractor to engage with local entities to promote Member needs for not only Medically Necessary health care services but also any supportive services as needed to treat the whole person and prevent avoidable negative health and social outcomes for individual Members to treat the whole person. This entails partnerships with Local Health Departments,

Local Educational and Government Agencies, and other local programs and services including county social services departments, Child welfare departments, and justice departments. This Article also establishes oversight of Memorandum of Understanding (MOU) requirements and requires referrals to ensure Member care is coordinated and community-based resources, including Community Supports, are availed. Beyond the MOU requirements, DHCS seeks to embed the whole person care and community-informed care approach within its Population Health Management (PHM) strategy and requires the same of Contractor. As such, this Article includes provisions requiring Contractor engagement with community representatives of diverse cultural and ethnic backgrounds to develop its PHM strategies.

To empower Members to become active participants in their care, DHCS has enhanced existing processes and created new channels for engagement for Members, families, and the community. Historically, Medi-Cal managed care plans are required to maintain a Community Advisory Committee (CAC), which serves to inform Contractor's cultural and linguistic services program. DHCS seeks to elevate the CAC by clarifying its role and member composition and prescribing Contractor's role in providing support for CAC members in order to maximize participation and involvement.

Exhibit A, ATTACHMENT III

5.1 Member Services

5.1.1 Member Rights and Responsibilities
5.1.2 Member Services Staff
5.1.3 Member Information
5.1.4 Primary Care Provider Selection
5.1.5 Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests

5.1 Member Services

5.1.1 Member Rights and Responsibilities

A. Member Rights and Responsibilities

Contractor must develop, implement, and maintain written policies and procedures that set forth the Member's rights and responsibilities and must communicate its policies to its Members, Providers, and, upon request, Potential Members.

1) Contractor's written policies and procedures must include the following Member rights:

a) To be treated with respect, giving due consideration to the Member’s right to privacy and the need to maintain confidentiality of the Member’s Protected Health Information (PHI) and private information.

b) To be provided with information about Contractor’s organization and all services available to Members.

c) To be able to choose their Primary Care Provider (PCP) within Contractor's Network unless the PCP is unavailable or is not accepting new patients.

d) To participate in decision-making regarding their health care, including the right to refuse treatment.

e) To submit Grievances, either verbally or in writing, about Contractor, Providers, care received, and any other expression of dissatisfaction not related to an Adverse Benefit Determination (ABD).

f) To request an Appeal of an ABD within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD) and request how to continue benefits during the in-plan Appeal process through the State Hearing, when applicable.

g) To request a State Hearing, including information on the circumstances under which an expedited State Hearing is available.

h) To receive interpretation services and written translation of critical informing materials in their preferred Threshold Language, including oral interpretation and American Sign Language.

i) To have a valid Advance Directive in place, and an explanation to Members of what an Advance Directive is.

j) To have access to family planning services and sexually transmitted disease services, from a Provider of their choice, without referral or Prior Authorization, either in or outside of Contractor's Network. To have Emergency Services provided in or outside of Contractor's Network, as required pursuant to federal law.

k) To have access to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Indian Health Care Providers (IHCP) outside of Contractor's Network, pursuant to federal law.

l) To have access to, and receive a copy of, their Medical Records, and request that they be amended or corrected, as specified in 45 Code of Regulations (CFR) sections 164.524 and 164.526.

m) To change Medi-Cal managed care plans upon request, if applicable.

n) To access Minor Consent Services.

o) To receive written Member informing materials in alternative formats, including Braille, large size print no smaller than 20 point font, accessible electronic format, and audio format, upon request and in accordance with 42 CFR section 438.10 and 45 CFR sections 84.52(d) and 92.102.

p) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

q) To receive information on available treatment options and alternatives, presented in a manner appropriate for the Member's condition and ability to understand available treatment options and alternatives.

r) To freely exercise these Member rights without retaliation or any adverse conduct by Contractor, Subcontractors, Downstream Subcontractors, Network Providers, or the State.

2) Contractor must provide its written policies and procedures regarding Member rights and responsibilities to its staff and all Network Providers, Subcontractors, and Downstream Subcontractors. Contractor must ensure that its staff, Network Providers, Subcontractors, and Downstream Subcontractors are trained and knowledgeable on Members' rights as required under Exhibit A, Attachment III, Section 3.2 (*Provider Relations*).

B. Member's Right to Confidentiality

Contractor must have policies and procedures in place to ensure Members' rights to confidentiality of PHI and Personal Information (PI) in accordance with 45 CFR parts 160 and 164, and in accordance with Civil Code section 1798 *et seq*.

1) Contractor must ensure that all Subcontractors, Downstream Subcontractors, and Network Providers have policies and procedures in place to guard against unlawful disclosure of PHI, PI, and any other Confidential Information to any unauthorized persons or entities.

2) Contractor must inform and advise Members on the right to confidentiality of their PHI and PI. Contractor must obtain the Member's prior written authorization to release Confidential Information, unless such prior written authorization is not required by ~~22 California Code of Regulations (CCR) section 51009~~ **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

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Handbook. Information in the Member Handbook must include the Member's right to be informed by Contractor of State law regarding Advance Directives, and to receive information from Contractor regarding any changes to that law. Contractor must ensure that the following statement, or similar language provided by DHCS is included:

Advance care planning for Members enrolled in Medi-Cal palliative care in accordance with All Plan Letter (APL) 18-020, must include documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, Advance Directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms.

2) Information on Advance Directives must comply with all State and federal law requirements and must be updated to reflect any changes to laws governing Advance Directives.

3) Contractor must ensure its Network Providers, Subcontractors, and Downstream Subcontractors are trained on complying with valid Advance Directives in accordance with 42 CFR sections 422.128 and 438.3(j).

D. Interoperability Requirements for Member Records

Contractor must implement and maintain a Patient Access Application Programming Interface (API) as specified in 42 CFR section 431.60 as if such requirements applied directly to Contractor, and as set forth in APL 22-026. The Patient Access API must also meet the technical standards in 45 CFR section 170.215. Data maintained on or after January 1, 2016, must be made available to facilitate the creation and maintenance of a Member's cumulative health record.

1) At a minimum, Contractor must permit third-party applications to retrieve, with the approval and at the direction of the Member, the following Member records:

a) Adjudicated claims data from Contractor, and from any Subcontractors, Downstream Subcontractors and Network Providers, including claims data and cost data that may be Appealed, or are in the process of Appeal, Provider remittances, and Member cost-sharing pertaining to such

claims, within (1) Working Day after a claim is processed;

b) Encounter Data, including Encounter Data from any capitated Subcontractors, Downstream Subcontractors, and Network Providers, within one (1) Working Day after receiving the data from Providers;

c) Clinical data, including diagnoses and related codes, and laboratory test results, within one (1) Working Day after the data is received by Contractor; and

d) Information about coverage for drugs administered in an outpatient setting as part of medical services, and updates to such information, including, if applicable, Member costs and any preferred drug list information, within one (1) Working Day after the effective date of any such information or updates to such information.

2) Contractor may deny or discontinue any third-party application's connection to an API if it reasonably determines, consistent with its security risk analysis under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule set forth in 45 CFR part 160 and 45 CFR part 164, subparts A and C, that continued access presents an unacceptable level of risk to the security of protected health information on its systems. The determination must be made using objective verifiable criteria that are applied fairly and consistently across all applications and developers, including but not limited to criteria that may rely on automated monitoring and risk mitigation tools.

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

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Contractor, fails to receive payment from either DHCS or Contractor; or

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.

F. Contractor must ensure that all Member Information is provided to Members at a sixth grade reading level and approved by DHCS before distribution. Member Information must inform Members on Contractor's processes and the Member's right to make informed health decisions.

1) Contractor must submit to DHCS for review and approval their policy and process for collecting requests and disseminating materials in an alternative format when requested by Member.

2) For Members with disabilities, including visual impairment Contractor must provide Member Information in all Threshold Languages, alternative formats as specified by DHCS and in APL 21-004 and APL 22-002 (including Braille, large-size print font no smaller than 20-point, accessible electronic format, audio compact disc (CD) format, or data CD format), and through Auxiliary Aids at no cost and upon request. Contractor must provide Member Information in a timely fashion appropriate for the format being requested and taking into consideration the special needs of Members with disabilities or Limited English Proficiency (LEP) Members.

a) Contractor must inform Members who exhibit or mention difficulty reading print communications of their right to receive Auxiliary Aids and services, including alternative formats.

b) For Members who request an electronic alternative format to receive Member information, Contractor must inform the Member that, unless they request a password-protected format, the Member Information will be provided in an electronic format that is not password protected, which may make the information more vulnerable to loss or misuse. Contractor must clearly communicate to Members that they may request an encrypted electronic format with unencrypted instructions on how the Member can access the encrypted information.

c) Contractor must accommodate the communication needs of qualified individuals with disabilities, which may include communication with the Member's Authorized Representative (AR) or someone with whom it is appropriate

for Contractor to communicate, such as a Member's disabled spouse. For these qualified individuals, Contractor must facilitate alternative format requests as identified in this Paragraph, as well as requests for other Auxiliary Aids and services.

3) Contractor must establish policies and procedures to ensure Members receive all Member Information in a Threshold Language or alternative format of their choice as required by 42 CFR section 438.10, W&I section 14029.91, and Exhibit A, Attachment III, Subsection 5.2.10.B (*Access Rights*).

4) Contractor must post a DHCS-approved nondiscrimination notice. Contractor must also post a notice with language taglines in a conspicuously visible font size in English, at least the top 15 non-English languages in the State, and any other languages, as determined by DHCS, explaining the availability of free language assistance services, including written translation and oral interpretation, and information on how to request Auxiliary Aids and services, including materials in alternative formats. The nondiscrimination notice and the notice with taglines must include Contractor's toll-free and Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) telephone number for obtaining these services, and must be posted as follows:

   a) In a conspicuous place in all physical locations where Contractor interacts with the public;

   b) In a location on Contractor's website that is accessible on Contractor's home page, and in a manner that allows Members, Potential Members, and members of the public to easily locate the information; and

   c) In the Member Handbook/EOC, and in all Member Information, informational notices, and materials critical to obtaining services targeted to Members, Potential Members, applicants, and the public at large, in accordance with APL 21-004 and APL 22-002, 42 CFR section 438.10(d)(2)-(3), and W&I section 14029.91(a)(3) and (f).

5) Contractor's nondiscrimination notice must include all information required by W&I section 14029.91(e), any additional information

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required by DHCS, and must provide information on how to file a Discrimination Grievance with:

a) Both Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56; and

b) The United States Department of Health and Human Services (U.S. DHHS) Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability, per W&I section 14029.91(e)(5).

G. Member Information Noticing in Electronic Format

1) Contractor has the option to send Members a notice in Member welcome packets or annual informational mailings to inform Members of how to obtain their Provider Directory and Member Handbook electronically or in a paper version if preferred. The notice can be an insert, flyer, or other form of noticeable communication.

a) Contractor may provide Seniors and Persons with Disabilities (SPDs) a notice in lieu of a paper Member Handbook in Member welcome packets. Contractor must still provide all SPDs with the paper form of the Provider Directory. The paper form of the Provider Directory may be a personalized, shorter version of the full-sized Provider Directory.

b) Contractor may provide their non-SPD, dual eligible Members a notice on how to access the Provider Directory and Member Handbook electronically in lieu of a paper version in Member welcome packets.

c) Contractor may provide all Members, except SPDs, a notice in lieu of a paper Provider Directory and Member Handbook for annual informational mailings.

2) Prior to using a notice, Contractor must submit the following to DHCS for approval:

a) A written proposal on Contractor's letterhead addressed to "DHCS Contract Manager" requesting to use a notice instead of mailing the informing materials. The proposal must include the following:

i. An overview of Contractor's process for utilizing the notice and how Contractor will meet all notice requirements.

ii. An explanation of the notice's purpose, including a description of the Member population(s) who will receive the notice.

iii. Time frame for implementation.

iv. A statement that Contractor is complying with all applicable State and federal laws, the requirements of this Contract, and other DHCS guidance, including APLs and Policy Letters (PLs).

v. For Member packages only, a proposal of how Contractor will move toward creating a personalized Provider Directory, with a timeline included that covers the cycle of production to delivery of personalized Provider Directories.

vi. Any other pertinent information necessary for DHCS to review.

b) A written policy and procedure describing in detail the process Contractor will utilize for the notice and how Contractor will continue to meet all language and format requirements set forth in 42 CFR section 438.10(d)(3), Provider Directory and website requirements in accordance with 42 CFR section 438.10(h), and sub-contractual relationship and delegation requirements set forth in 42 CFR section 438.230.

c) A sample of Contractor's proposed notice regarding electronic communications. The notice must be easily identifiable by the Member, state the purpose of each piece

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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

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and data and submit as required by 42 CFR section 438.10(h)(3). Contractor's Provider Directory must also comply with all requirements in PL 11-009. DHCS is authorized to require changes or corrections to Contractor's Provider Directory at any time.

6) Contractor must implement and maintain a publicly accessible standards-based Provider Directory API, as described in 42 CFR section 431.70 and APL 22-026, which must include the information required here in Exhibit A, Attachment III, Subsection 5.1.3.H (*Member Information*). The Provider Directory API must meet the technical standards in 45 CFR section 170.215, excluding the security protocols related to user authentication and authorization.

7) Provider Directories must comply with 42 CFR section 438.10(h) and H&S section 1367.27, and must include the following information for in-Network PCP, Specialists, hospitals, Enhanced Care Management (ECM), Community Support Providers, Behavioral Health Providers, and any other Providers (e.g., Community Health Workers (CHW)) contracted for Medi-Cal Covered Services:

   a) The Provider's or site's location name and any group affiliation(s), National Provider Identifier (NPI) number, street address(es), all telephone numbers associated with the practice site, and, if applicable, website URL for each Service Location;

   b) Provider's specialty type and paneling status that allows them to treat specific populations, including but not limited to, whether they are a California Children's Services (CCS paneled provider;

   c) Whether the Provider is accepting new patients;

   d) Information on the Provider's affiliated medical group or Independent Physician/Provider Associations (IPA), NPI number, address, telephone number, and, if applicable, website URL for each Physician Provider of affiliated group or IPA;

   e) The hours and days when each Service Location is open, including the availability of evening or weekend hours;

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f) The services and benefits available, including accessibility symbols approved by DHCS confirming whether the office/facility (exam room(s), equipment, etc.) can accommodate Members with physical disabilities as required by PL 11-009;

g) The Provider's cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered either by the Provider or a skilled medical interpreter at the Provider's facility;

h) The telephone number to call after normal business hours;

i) Identification of Network Providers or sites that are not available to all or new Members

j) The link to the Medi-Cal Rx Pharmacy Locator, which can be found on the dedicated Medi-Cal Rx website described in APL 22-012.

I. Member Handbook

Contractor must comply with the requirements in 22 CCR section 53895(b) by distributing a Member Handbook, also known as an Evidence of Coverage and Disclosure Form (EOC/DF) to each Member and to Potential Members, upon request. The Member Handbook must meet all requirements in 42 CFR section 438.10(g), 22 CCR section 53881, and any other requirements in State and federal law, and this Contract. In addition, the Member Handbook must meet all applicable requirements contained in 42 CFR section 438.10(d), W&I section 14029.91, 22 CCR section 53876 for Limited English Proficiency (LEP) Members and Potential Members and H&S section 1363 as to translation, print size, readability, and understandability of text.

1) Contractor must provide to each Member, or Member's family unit, a Member Handbook that constitutes a full and fair disclosure of the Member's right to obtain and Contractor's provision of all Medi-Cal services that are available and accessible to the Member. Contractor must post its most recent Member Handbook to its website.

2) Contractor must use the DHCS template for its Member Handbook. Contractor must submit its information that is specific to Contractor, where applicable. Contractor must submit its completed Member

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Handbook, with all Contractor-specific information included in redline, for review and approval by DHCS before distribution to Members.

3) Contractor must make the revised Member Handbook available to Members based on the timeframes required by State and federal law and at any time DHCS, a Member, or a Potential Member requests a copy.

4) Although Contractor is required to use the DHCS Member Handbook template, Contractor remains solely responsible for ensuring that Members receive the following information through the Member Handbook:

   a) Contractor's name, address, toll-free telephone number(s) for Member services, Medi-Cal Rx telephone number(s) and website information, any other Contractor staff providing services directly to Members, and information on Contractor's Service Area;

   b) Information on how to access services in the Medi-Cal managed care system, including a description of the full amount, duration, and scope of Covered Services and how to obtain services under this Contract. The Member Information must also include information on services that require Prior Authorization and how to request it, health education and how to access appropriate community resources and other agencies, interpretive services provided by Contractor's staff and at service sites, and an explanation of "carved- out" services, including Specialty Mental Health Services, and any service limitations and exclusions from coverage or charges for services. The Member Handbook must also include information on services to which Contractor, Subcontractor, Downstream Subcontractor, or a Network Provider may have a moral objection to perform or support and alternative methods for obtaining those services;

   c) Procedures for accessing Covered Services, which explain that Covered Services will be obtained through Contractor's Network Providers unless otherwise allowed under this Contract;

d) A description of the Member identification card issued by Contractor, if applicable, and an explanation of its use in authorizing or assisting Members in obtaining services;

e) Procedures for selecting or requesting a change in PCP at any time, any requirements for a Member to change their PCP, reasons for which a request for a specific PCP may be denied, and reasons why a PCP may request a change;

f) The purpose and value of scheduling and completing an Initial Health Appointment (IHA);

g) The availability and procedures for obtaining after-hours services 24 hours a day, seven days a week, including the appropriate Network Provider locations and telephone numbers to obtain services. This must include an explanation of the Members' right to interpretive services, at no cost, to assist in receiving after-hours services;

h) Definition of what constitutes an Emergency Medical Condition, Emergency Services, and post-stabilization services. The Member Handbook must expressly state that Prior Authorization is not required to receive Emergency Services and include the use of 9-1-1 for obtaining Emergency Services;

i) The right to receive Emergency Services in any hospital or other setting, and procedures for obtaining Emergency Services from specified Network Providers or from out-of-Network Providers, including Emergency Services outside of Contractor's Service Area. This includes the right to the provision of at least a 72-hour supply of Medically Necessary medication in an emergency situation is provided;

j) Process for referral to Specialists, including an explanation of the Prior Authorization process, in sufficient detail so the Member can understand how the process works, including authorization and referral timeframes and alternative access standards as required by W&I section 14197.04, APL 23-001, and APL 21-011;

k) Procedures for obtaining Emergency Medical Transportation (EMT) and Non-Emergency transportation services to service sites that are offered by Contractor or available

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through the Medi-Cal program, and how to obtain such services. Include a description of medical transportation, including EMT, Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) services, and how Contractor coordinates access to appropriate transportation, when needed;

l) The right to file a Grievance and request an Appeal with Contractor, and procedures for filing either orally, in writing, or over the phone. Contractor must inform Members of all Appeal and State Hearing rights when it makes a decision to deny, delay or modify a Member's request for services as set forth in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

m) Information on disenrollment from Contractor. Contractor must ensure that the following information is included:

i. The causes for which a Member may lose eligibility to receive services under this Contract as set forth in Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*), and the procedures for disenrollment due to the loss of eligibility.

ii. An explanation of the expedited disenrollment process for Members qualifying under conditions specified under 22 CCR section 53889(j), which includes Children receiving services under the Foster Care or Adoption Assistance Programs, Members who require out-of-Network transplant services if they are unavailable in-Network, and Members already enrolled in another Medi-Cal, Medicare, or commercial managed care plan.

n) An explanation of the Member's right to disenroll at any time, and reenroll in the competing Medi-Cal managed care plan in the county (in counties where another Medi-Cal managed care plan is available), subject to the requirements in 22 CCR 53889, 22 CCR 53891(c) and any restricted disenrollment period;

o) Information on the Member's right to a Medi-Cal State Hearing, the process for obtaining a State Hearing, the timeframe to request a State Hearing, and the rules that

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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 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

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health care, diagnostic services, treatments, and other measures listed in 42 United States Code (USC) section 1396d(a) and (r), whether or not covered under the California Medicaid State Plan. All EPSDT services are Covered Services unless expressly excluded under this Contract;

x) An explanation on how to use the Medi-Cal Fee-For-Service (FFS) system when Medi-Cal services are excluded or limited under this Contract, and how to obtain additional information;

y) An explanation that an American Indian Member's status as a Member is voluntary and that an American Indian Member cannot be required to enroll in a Medi-Cal managed care plan and has the right to access IHCP, choose an IHCP within Contractor's Network as a PCP, and disenroll from Contractor at any time, without cause;

z) Language regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor, pursuant to H&S section 7158.2. This information must be provided in the Member Handbook as well as Contractor's newsletter and any other direct communication with Members, and must be provided the Members annually under H&S section 7158.2;

aa) Confirmation of whether Contractor offers financial bonuses or other incentives to its Network Providers. This information must inform the Member of the right to request additional information about these bonuses or incentives from Contractor, their Network Provider, or the Network Provider's medical group or IPA, pursuant to H&S section 1367.10;

bb) Instructions on how a Member can request a copy of, or the website link to locate, Contractor's non-proprietary clinical and administrative policies and procedures;

cc) That oral interpreter services are available for any language spoken by the Member, and that the Member can inform Contractor of their preferred language to receive written translations of Member materials in the identified Threshold Languages, both free of charge, with instruction on

Contractor's obligations to ensure these services are provided;

dd) That Auxiliary Aids and services are available upon request and at no cost for Members with disabilities, and how to access these services;

ee) Information on how to report suspected Fraud, Waste and Abuse; and

ff) Information on how to request Community Supports.

J. Member Identification Card

Contractor must provide an identification card to each Member, which identifies the Member and authorizes them to access Covered Services. The card must inform the Member that they may seek Emergency Services from out-of-Network Providers. The card must inform the Member of the Medi-Cal Rx telephone number. The Member identification card must also inform the Member that Emergency Services are covered by Contractor without Prior Authorization, and at no cost to the Member.

5.1.4 Primary Care Provider Selection

A. Contractor must implement and maintain DHCS-approved procedures to ensure that each new Member who is not enrolled in comprehensive Other Health Coverage (OHC) has an appropriate and available PCP. Comprehensive OHC refers to:

1) Members with the OHC Code indicator C, H, F, K, or P as listed in the 834 file, or,

2) OHC with a scope of coverage of at least Outpatient, Inpatient, and Medical/Allied (OIM) Services found in positions 119 through 126 in the Health Insurance System Database (HISDB) file.

B. Contractor must provide each new Member an opportunity to select a PCP within the first 30 calendar days of Enrollment. Contractor must make best efforts to ensure the Member is assigned to the PCP the Member selected at the time of their Enrollment, unless the PCP is unavailable or is not accepting new patients.

C. If the Member does not select a PCP within 30 calendar days of the effective date of Enrollment, Contractor must assign that Member to a

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PCP and notify the Member and the assigned PCP no later than 40 calendar days after the Member's Enrollment. Contractor must ensure that adverse selection does not occur when Members are assigned to PCPs.

1) Contractor must allow Members to select a clinic that provides Primary Care in lieu of selecting a specific PCP, where available.

2) If Contractor's Network includes Nurse Practitioners (NP), Certified Nurse Midwives (CNMs), OB-GYN, or Physician Assistants, the Member may select one of these practitioners as their PCP within 30 calendar days of Enrollment to provide Primary Care services in accordance with 22 CCR section 53853(a)(4).

3) SPD Members may select a Specialist or clinic as a PCP if the Specialist or clinic agrees to serve as the Member's PCP and is qualified to treat the health conditions of the SPD Member, in accordance with W&I section 14182(b)(11).

4) Contractor must ensure that Members are allowed to change their PCP, NP, CNM, or Physician Assistant assignment, upon request, by selecting a different PCP from Contractor's Network.

D. Contractor must inform Members through direct outreach to provide an explanation for the reason the Member could not be assigned to their selected PCP.

E. Contractor must ensure that Members who have an established relationship with a Network Provider, and who want to continue their patient-Provider relationship, are assigned to that Provider without disruption in the Member's care if the Member's existing relationship meets the requirements set forth in APL 18-008 (revised).

F. Contractor must ensure that Members can choose Traditional and Safety-Net Providers as their PCP, and that American Indian Members may choose an IHCP within Contractor's Network as their PCP.

G. Contractor is not obligated to require full benefit dual eligible Members to select a Medi-Cal PCP. Nothing in this section must be construed to require Contractor to pay for services that would otherwise be paid for by Medicare.

H. If a Member does not select a PCP within 30 calendar days of the effective date of Enrollment, Contractor must use utilization data or other data sources in its possession or provided by DHCS to select a PCP for

the Member. This includes review of electronic data to confirm existing Provider relationships for the purpose of PCP assignment, including a Specialist or clinic for an SPD if they have indicated they have a preference for either to act as their PCP. Contractor must comply with all federal and State privacy laws in the provision and use of this data.

I. Contractor must notify the PCP that a Member has selected or been assigned to the Provider within ten calendar days from the date selection or assignment is complete.

J. Contractor must maintain procedures that proportionately include contracting with Traditional and Safety-Net Providers in the assignment process for Members who do not choose a PCP. Contractors in public hospital health system counties must assign PCPs in compliance with W&I section 14199.1.

5.1.5 Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests

Contractor must notify Members of a decision to deny, defer, or modify requests for Prior Authorization, in accordance with 42 CFR section 438.210(c) and 22 CCR sections 51014.1 and 53894 by providing a NOA to Members and/or their AR, regarding any denial, deferral, or modification of a request for approval to provide a health care service. This notification must be provided in accordance with all requirements set forth in Exhibit A, Attachment III, Subsection 4.6.4 (*Notice of Action*).

Exhibit A, ATTACHMENT III

5.2 Network and Access to Care

5.2.1 Access to Network Providers and Covered Services
5.2.2 Network Capacity
5.2.3 Network Composition
5.2.4 Network Ratios
5.2.5 Network Adequacy Standards
5.2.6 Access to Emergency Service Providers and Emergency Services
5.2.7 Out-of-Network Access
5.2.8 Specific Requirements for Access to Programs and Covered Services
5.2.9 Network and Access Changes to Covered Services
5.2.10 Access Rights
5.2.11 Cultural and Linguistic Programs and Committees
5.2.12 Continuity of Care for Seniors and Persons with Disabilities
5.2.13 Network Reports
5.2.14 Site Review
5.2.15 Street Medicine

5.2 Network and Access to Care

5.2.1 Access to Network Providers and Covered Services

A. Primary Care

1) Contractor must ensure that each Member has an assigned Primary Care Provider (PCP) who is available and physically present at the Service Location for sufficient time to ensure access and appointments for the assigned Member when medically required. This requirement does not preclude an appropriately licensed Provider from being a substitute for the Member's assigned PCP in the event of vacation, illness, or other unforeseen circumstances.

2) Contractor must have processes in place to assist Members in selecting PCPs who are accepting new patients.

3) Contractor must consider the requirements in Welfare and Institutions Code (W&I) section 14182(b)(11) when assigning Members who are Seniors and Persons with Disabilities (SPD) to a PCP. Additionally, Contractor must ensure that Members have the option of selecting an Indian Health Care Provider (IHCP), Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC), as their PCP, where available.

B. Specialists

1) Contractor must ensure that Members have access to Specialists for Medically Necessary Covered Services in accordance with W&I section 14197, 22 CCR section 53853, and 28 CCR section 1300.67.2.2.

2) Contractor must maintain an adequate Network that includes adult and pediatric Specialists, and at a minimum, the core Specialists required in W&I section 14197(h)(2), within its Network to ensure Medically Necessary specialty care is available in accordance with 22 CCR section 53853(a), and W&I sections 14182(c)(2) and 14197.

C. Contractor must ensure its Network Providers, Subcontractors, and Downstream Subcontractors have adequate Networks and staff within its Service Area, including Physicians, nurses, and administrative and other support staff to ensure that they have sufficient capacity to provide and

coordinate care for Covered Services are provided in accordance with W&I section 14197, 22 CCR section 53853, 28 CCR section 1300.67.2.2, and all requirements in this contract.

D. Contractor must monitor Subcontractors and Downstream Subcontractors to ensure they can adequately deliver culturally and linguistically competent care including offering interpreter services when a Limited English Proficient (LEP) Member accesses a Provider who does not speak the Member's language.

E. Contractor must ensure that Members have access to all Non-specialty Mental Health and Substance Use Disorder (SUD) Covered Services in accordance with 42 Code of Federal Regulations (CFR) section 438.900 *et seq.* Contractor must coordinate care for all Specialty Mental Health Services (SMHS) and SUD services and provide referrals including mechanisms to track completion of follow up visits, to the county mental health plan (MHP) and Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services as outlined in Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*)

5.2.2 Network Capacity

A. Contractor must maintain a Network adequate to provide the full scope of benefits to 60 percent of all Potential Members or current Member Enrollment, whichever is higher, within its Service Area. Contractor must increase the capacity of the Network as necessary to accommodate all Enrollment growth beyond the 60 percent.

B. Contractor may request to renegotiate its Network capacity requirement with DHCS if utilization by Contractor’s Members does not exceed 75 percent of the required Network capacity, after the first 12 months of operation. Any such change is subject to DHCS review and approval.

5.2.3 Network Composition

A. Contractor must maintain an adequate Network within its Service Area, in compliance with W&I section 14197, and if necessary to ensure contract compliance with Network adequacy. Contractor may offer to contract with Providers in adjoining Service Areas but must make good faith efforts to contract with Providers within Contractor’s Service Area. Contractor’s Network must include at a minimum adult and pediatric PCPs, obstetrics, and gynecology (OB/GYNs), adult and pediatric Behavioral Health Providers, adult and pediatric Non-specialty outpatient Mental Health Service (NSMHS) Providers, adult and pediatric Specialists, hospitals, and

Long-Term Care (LTC) Providers to ensure adequate access to all Medically Necessary Covered Services for all Members and to meet all Network adequacy requirements.

B. Contractor must maintain an adequate Network of Allied Health Personnel, supportive paramedical personnel, public hospitals and health care systems, care navigators, caseworkers, and public health nurses, and an adequate number of accessible service sites to ensure adequate access to all Medically Necessary Covered Services for all Members.

C. Contractor must include in its Network, where available, IHCP, FQHC, RHCs, Freestanding Birthing Centers (FBC), Certified Nurse Midwives (CNMs), and Licensed Midwives (LM) in accordance with W&I section 14087.325, Medicaid State Health Official Letter #16-006, All Plan Letter (APL) 18-022, and APL 23-001.

1) If Contractor is a local initiative health plan model, it must offer to contract with all FQHCs and RHCs in its county(ies), in accordance with W&I section 14087.325. Local initiative health plans must maintain and provide supporting documentation of all contracting efforts with each FQHC and RHC in its county(ies) to DHCS upon request, even if Contractor has a minimum of one active contract with an FQHC and RHC in their county(ies).

2) If Contractor is not a local initiative health plan model, it must contract with a sufficient number of and include at least one FQHC, one RHC, and one FBC in the Network, where available in Contractor's Service Area(s), to the extent that the FQHC, RHC, and FBC Providers are licensed and recognized under State law.

D. Contractor must offer to contract with all IHCP available in each county(ies) in which Contractor operates in accordance with 22 CCR section 55120. If Contractor is unable to contract with an IHCP, Contractor must allow eligible Members to obtain services from out-of-Network IHCP in accordance with 42 CFR section 438.14.

E. Contractor must make good faith efforts to contract with at least one cancer center within their Networks and subcontracted Networks, if applicable, within each county in which Contractor operates for the provision of Covered Services to any eligible Member diagnosed with complex cancer diagnosis in accordance with W&I section 14197.45.

F. Contractor must continually ensure that the composition of its Network meets the ethnic, cultural, and linguistic needs of Contractor's Members.

G. Contractor must have an adequate number of NSMHS Providers to provide Medically Necessary, NSMHS based on current and anticipated utilization trends for its Members.

H. Contractor must include in its Network any traditional and Safety-Net Provider that is willing to contract under the same terms and conditions that Contractor offers to any other similar Provider in accordance with 22 CCR section 53800(b)(2)(C)(1).

I. Contractor must ensure that every LTC Provider in its Service Area that is licensed by the California Department of Public Health (CDPH) as a qualified LTC Provider is included in Contractor's Network, to the extent that the LTC Provider remains licensed, certified, operating, and is willing to enter into a Network Provider Agreement with Contractor on mutually agreeable terms and meets Contractor's Credentialing and quality standards. If Contractor determines that additional LTC Providers are necessary to meet the needs of its Members, Contractor must offer to contract or enter into a letter of agreement with any additional CDPH licensed LTC Providers in its Service Area or in adjoining Service Areas.

J. Contractor must receive a preapproval or assessment of suitability from CDPH prior to the execution of a Network Provider Agreement for LTC Providers undergoing a change of ownership. Network Provider Agreements must have a clause that LTC Providers must notify Contractor if it is undergoing a change of ownership so Contractor can obtain preapproval or assessment of suitability from CDPH.

K. Contractor must ensure that every CBAS Provider within Contractor's Service Area, that has been approved by the California Department of Aging (CDA) as a CBAS Provider, is included in Contractor's Network to the extent that the CBAS Provider remains licensed as an Adult Day Health Care (ADHC) Center, is certified and enrolled as a Medi-Cal Provider, is willing to enter into a Network Provider Agreement with Contractor on mutually agreeable terms, and meets Contractor's credentialing and quality standards. Contractor must contract with a sufficient number of Community-Based Adult Service (CBAS) Providers to timely meet the needs of Members who are CBAS-eligible. Contractor must have an adequate number of CBAS Providers that are geographically located within one hour's transportation time of its CBAS-eligible Members and that are appropriate for and proficient in addressing CBAS-eligible Members' specialized health needs and acuity, communication, cultural, and language needs and preferences. Contractor must also meet expected CBAS-utilization without a waitlist.

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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,

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.

B. Time or Distance

1) Contractor must ensure that its Network Providers, Subcontractors, and Downstream Subcontractors meet the time or distance standards for adult and pediatric PCPs, adult and pediatric core Specialists, OB/GYN primary and specialty care, adult and pediatric mental outpatient health Providers, and hospitals, as required by W&I section 14197(b) and (c).

2) Contractor must either exhaust all other reasonable options for contracting with Providers, including offering to contract with Providers in adjoining Service Areas, or provide evidence to DHCS demonstrating that its delivery structure is capable of delivering the appropriate level of care and access as required by W&I section 14197 prior to submitting an Alternate Access Standard (AAS) request to DHCS.

3) If Contractor is unable to comply with the time or distance standards set forth in W&I section 14197, Contractor must submit an AAS request to DHCS for review and approval in accordance with APL 23-001, detailing how it intends to arrange for Covered Services in accordance with W&I section 14197(e)(3).

4) Contractor must publish on its website its approved AAS requests in accordance with W&I section 14197.04.

5) If Contractor has received an AAS approval from DHCS for a core Specialist, upon a Member's request, Contractor must assist the Member in obtaining an appointment with the appropriate core Specialist in accordance with W&I section 14197.04. Contractor must either make its best effort to establish a Member-specific case agreement with an out-of-Network Provider or arrange for an appointment with a Network Provider in an adjoining Service Area within the time or distance standards in accordance with W&I section 14197.04. If needed, Contractor must assist in arranging transportation for the Member. Contractor must not be held liable for fulfilling these requirements if either there is no core Specialist within the time or distance standards of this Contract, or the core Specialist has refused to contract in the previous 12 months.

5.2.6 Access to Emergency Service Providers and Emergency Services

A. Contractor must have within its Network, at a minimum, a designated Emergency Services facility, providing care 24 hours a day, seven days a week. This designated Emergency Services facility must have one or more Physicians and one nurse on duty in the facility at all times.

B. Contractor must ensure that Members with Emergency Medical Conditions are seen on an emergency basis and that Emergency Services are available and accessible within Contractor's Service Area seven days a week, 24 hours a day, in accordance with 42 USC sections 1395dd and 1396u-2(b)(2), 42 CFR sections 438.114 and 438.206(c)(1)(iii), and 28 CCR 1300.67(g)(1).

C Contractor must reimburse the costs of Emergency Services without Prior Authorization pursuant to 42 USC section 1395dd, 42 CFR section 438.114, 28 CCR section 1300.67(g), and 22 CCR section 53216 and 53855.

D. Contractor must have a medical director or licensed physician acting on behalf of Contractor's medical director, who is available 24 hours a day, seven days a week to authorize Medically Necessary Post-Stabilization Care Services, to respond to hospital inquiries within 30 minutes, and to coordinate the transfer of a Member whose Emergency Medical Condition is stabilized.

E. Contractor must ensure that Members have timely access to Medically Necessary follow-up care including but not limited to appropriate referrals to Primary Care, Behavioral Health Services, and social services for Members who have been screened in the emergency room and do not require Emergency Services.

F. Contractor must coordinate access to Emergency Services in accordance with Contractor's DHCS-approved emergency department protocol, as required in Exhibit A, Attachment III, Section 3.2 (*Provider Relations*).

G. If Contractor delegates its Emergency Services and Post-Stabilization Care Services oversight obligations to Network Providers, Subcontractors, or Downstream Subcontractors, it must ensure a licensed physician is available seven days a week, 24 hours a day, to authorize Medically Necessary Post-Stabilization Care Services and coordinate the transfer of stabilized Members in an emergency department to an appropriate Network Provider, if necessary, as required under Health & Safety Code (H&S) section 1371.4.

5.2.7 Out-of-Network Access

A. Contractor must authorize and arrange for out-of-Network access in the following circumstances:

1) Contractor does not meet Network adequacy requirements set forth in W&I section 14197;

2) Contractor does not have an AAS approved by DHCS and fails to meet the Network adequacy standards set forth in W&I section 14197;

3) Contractor fails to comply with the requirements for timely access to appointments; or

4) Contractor must arrange for access to out-of-Network LTC when Medically Necessary for a Member in cases where Contractor does not have in-Network LTC capacity.

B. Contractor must authorize and arrange for services from out-of-Network Providers when the Provider type is unavailable within the Network but available in an adjoining county(ies). If there is no Network Provider in the adjoining county(ies), Contractor must authorize out-of-Network services to the most appropriate Provider as close to time or distance requirements as possible.

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C. Contractor must provide Non-Emergency Medical Transportation (NEMT) or Non-Medical Transportation (NMT) to the out-of-Network Provider, at no cost to the Member. Contractor must inform Members of their right to obtain NEMT or NMT services to access out-of-Network services in accordance with W&I section 14197.04.

D. Contractor must adequately and timely cover and reimburse Providers for out-of-Network services rendered to its Members for as long as Contractor is unable to provide these services in its Network. Contractor must ensure that the Member is not charged for services furnished out-of-Network. Contractor must also ensure that Members are not balance-billed for any service provided out-of-Network.

5.2.8 Specific Requirements for Access to Programs and Covered Services

A. Family Planning Services

1) Contractor must ensure Members have access to family planning services through any available family planning Provider regardless of whether they are in or out of the Network, without requiring Prior Authorization. Contractor must provide family planning services in a manner that ensures Members have the freedom to choose their preferred method of family planning consistent with 42 CFR section 441.20.

2) Contractor must not restrict a Member's Provider choice for family planning services covered pursuant to 42 CFR section 431.51(a)(3) and W&I section 14132.07.

3) Contractor's Member Handbook must inform Members of their right to access any qualified family planning Provider regardless of whether the Provider is in the Network and without Prior Authorization, in addition to requirements included in Exhibit A, Attachment III, Section 5.1 (*Member Services*).

4) Contractor must ensure that Members are advised of their options for all contraceptive methods to allow them to provide informed consent for their choice of contraceptive method, including sterilization, as required by 22 CCR sections 51305.1 and 51305.3. Members of childbearing age may access the following services from an out-of-Network family planning Provider to temporarily or permanently prevent or delay pregnancy:

a) Health education and counseling necessary to make informed choices and understand contraceptive methods;

b) Limited history and physical examination;

c) Laboratory tests if medically indicated as part of the decision-making process in choice of contraceptive methods, except pap smears if Contractor provides pap smears to meet the United States Preventive Services Taskforce (USPSTF) guidelines, http://www.uspreventiveservicestaskforce.org;

d) Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning Provider;

e) Provision of contraceptive pills, devices, and supplies;

f) Tubal ligation;

g) Vasectomies; and

h) Pregnancy testing and counseling.

B. Sexually Transmitted Diseases

Contractor must ensure Members have access to Sexually Transmitted Disease (STD) services from any Network Provider or out-of-Network Provider without requiring Prior Authorization or referral. Contractor must allow Members to access out-of-Network STD services through Local Health Department (LHD) clinics, family planning clinics, or through other community STD service Providers.

C. HIV Testing and Counseling

Contractor must ensure that Members have access to confidential Human Immunodeficiency Virus (HIV) counseling and testing services from any Network Provider or out-of-Network Provider without requiring Prior Authorization.

D. Minor Consent Services

Contractor must ensure access to Minor Consent Services for Members less than 18 years of age from any Network Provider or out-of-Network

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Provider without requiring Prior Authorization. Contractor must ensure Members are informed of the availability of these services without Prior Authorization. Minors less than 18 years of age do not need parent, legal guardian, or Authorized Representative (AR) consent to access these services, and Contractor, Network Providers, Subcontractors, or Downstream Subcontractors are prohibited from disclosing any information relating to Minor Consent Services without the express consent of the minor Member. Minor Consent Services include treatment for the following:

1) Sexual assault, including rape;

2) Drug or alcohol abuse for Children ages 12 and over;

3) Pregnancy;

4) Family planning

5) STDs in Children ages 12 and over;

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

7) NSMHS for Children ages 12 and over 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.

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

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CBAS Provider from its Network. DHCS may attempt to resolve the contracting issue when appropriate.

4) In accordance with APL 21-003, Contractor must notify DHCS within 60 calendar days of termination of a LTC Network Provider or immediately if the termination is a result of the LTC Network Provider having been decertified by the California Department of Public Health (CDPH). DHCS will attempt to resolve the contracting issue when appropriate. If termination of a LTC Network Provider Agreement is for a cause related to Quality of Care or patient safety concerns, Contactor may expedite termination of the LTC Network Provider Agreement and transfer Members to an appropriate, contracted LTC Provider in an expeditious manner. DHCS must be notified of the termination within 72 hours of said termination. Contractor must not continue to assign or refer Members to a LTC Network Provider during the 60 calendar days between notifying DHCS and the termination effective date.

B. Member Notification Requirements

1) Contractor must ensure Members are notified in writing of any changes in the availability or location of Covered Services, of any termination of a Network Provider, Subcontractor, or Downstream Subcontractor either 30 calendar days prior to the effective date of the contract termination or at least 15 calendar days after receipt of issuance of the termination notice, whichever is longer, unless directed by DHCS. The notification must be provided to each Member who received Primary Care from, or was seen on a regular basis by, the terminated Provider. This notification must also be submitted to DHCS in writing for approval before its release.

2) Contractor must obtain DHCS approval before sending a notice of termination to its Members no later than 60 calendar days prior to the effective date of the termination. Contractor may use a member notice template previously approved by DHCS. Any changes from the approved template must be submitted to DHCS 60 calendar days prior to the effective date of the termination for review and approval before mailing the notice. In the event of an emergency or other unforeseeable circumstance, Contractor must provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible.

5.2.10 Access Rights

A. Equal Access for Linguistic Services

Contractor must ensure equal access to the provision of high quality interpreter and linguistic services for LEP Members and Potential Members, and for Members and Potential Members with disabilities, in compliance with federal and State law, and APL 21-004.

B. Linguistic Services

1) Contractor must comply with W&I section 14029.91 and ensure that all monolingual, non-English-speaking, or LEP Members and Potential Members receive 24-hour interpreter services at all key points of contact, as defined in Paragraph B.4) of this provision, either through interpreters, telephone language services, or other legally compliant electronic options.

2) Contractor must ensure that any lack of interpreter services does not impede or delay a Member's timely access to care.

3) Contractor must comply with Title VI of the Civil Rights Act of 1964 and 42 CFR section 438.10(d) and have the capacity to provide, at minimum, the following linguistic services at no cost to Members or Potential Members:

a) Oral interpreters, sign language Providers, or bilingual Network Providers, Network Provider staff, Subcontractors, and Downstream Subcontractors at all key points of contact. These services must be provided in all languages spoken by Medi-Cal Members and Potential Members and not limited to those that speak the threshold or concentration standards languages.

b) Full and immediate translation of written materials pursuant to 42 CFR sections 438.10(d)(3), 438.404(a), and 438.408(d); W&I section 14029.91; and 22 CCR section 53876 for LEP Members and Potential Members who speak Threshold or Concentration Standard Languages, fully translated Member Information, including: the Member Handbook, Provider Directory, welcome packets, Marketing information, Member rights information, form letters and individual notices, including Notice of Action (NOA) letters, all notices related to Grievances and Appeals including Grievance and Appeal acknowledgement and resolution

letters, and any other materials as required by Title VI of the Civil Rights Act of 1964 and APL 21-004;

c) Referrals to culturally and linguistically appropriate community service programs; and

d) Auxiliary Aids such as Telephone Typewriters (TTY)/ Telecommunication Devices for the Deaf (TDD), qualified interpreters including American Sign Language interpreters, and information in alternative formats including Braille, large print text (20 point font or larger), audio, and electronic formats, in accordance with written informing materials in alternative formats, selected by the Member, as specified in APL 21-004 and APL 22-002.

4) Key points of contact include:

a) Medical care settings, such as telephone, advice and Urgent Care transactions, and outpatient Encounters with Providers; and

b) Non-medical care settings, such as Member services, orientations, and appointment scheduling.

C. Access for Persons with Disabilities

Contractor must comply with the requirements of Titles II and III of the Americans with Disabilities Act of 1990 (42 USC sections 12131 et seq. and 12181 et seq.), section 1557 of the Affordable Care Act of 2010 (42 USC section 18116), sections 504 and 508 of the Rehabilitation Act of 1973 (29 USC sections 794 and 794d), Government Code (GC) sections 7405 and 11135, and all applicable implementing regulations, and must ensure access for people with disabilities including, without limitation, accessible web and electronic content, ramps, elevators, accessible restrooms, designated parking spaces, and accessible drinking water.

5.2.11 Cultural and Linguistic Programs and Committees

A. Cultural and Linguistic Program

1) Contractor must develop and implement policies and procedures for assessing the performance of its employees, contracted staff, and other individuals who provide linguistic services, addressing any identified gaps in the provision of cultural and linguistic services

by Contractor's staff, and for overall monitoring and evaluation of its cultural and linguistic services programs.

2) Contractor must have in place and continually monitor, improve, and evaluate cultural and linguistic services that support the delivery of Covered Services to Members. Contractor must ensure it has proper policies and procedures in place to provide appropriate cultural and linguistic services for all of its Members.

3) Contractor must take immediate action to improve the delivery of culturally and linguistically appropriate services when deficiencies are noted.

4) Contractor must be active in recruiting and retaining culturally and linguistically competent Providers that reflect the needs of the Medi-Cal population in Contractor's Service Area.

5) Contractor must have a cultural and linguistic services program, as required by 22 CCR section 53876, that incorporates all requirements of applicable federal and State law, including without limitation those requirements cited in Exhibit A, Attachment III, Subsection 5.2.10 (*Access Rights*), 42 CFR section 438.206(c)(2), 22 CCR sections 51202.5 and 51309.5(a), and 28 CCR sections 1300.67.04(c)(2)(A) - (B) and 1300.67.04(c)(2)(G)(v) - (c)(4). Contractor must ensure immediate translation of all critical Member Information as required by 42 CFR sections 438.10, 438.404(a), and 438.408(d), and W&I section 14029.91.

6) Contractor must review and update its cultural and linguistic services programs to align with the Population Needs Assessment (PNA) implementation and subsequent findings. Contractor must ensure its Network Providers, Subcontractors, Downstream Subcontractors cultural and Health Equity linguistic services programs also align with the PNA.

7) Contractor must implement and maintain a written description of its cultural and linguistic services program which must include, at a minimum, the following:

   a) Its organizational commitment to deliver culturally and linguistically appropriate health care services;

   b) Services that comply with Title VI of the Civil Rights Act of 1964 (42 USC section 2000e et seq.), section 1557 of the

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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

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address Members' cultural and linguistic needs. The training must include instruction on:

1) Contractor's policies and procedures for language assistance;

2) How to work effectively with LEP Members and Potential Members;

3) How to work effectively with interpreters in person and through video, telephone, and other media; and,

4) Understanding the cultural diversity of Members and Potential Members, and sensitivity to cultural differences relevant to delivery of health care interpretation services, in accordance with Exhibit A, Attachment III, Subsection 5.2.11 *(Cultural and Linguistic Programs and Committees).*

C. Diversity, Equity, and Inclusion Training

Contractor must provide annual sensitivity, diversity, cultural competency/humility and Health Equity training for its employees and contracted staff as detailed in APL 23-025. Training must consider structural and institutional racism and Health Inequities and their impact on Members, staff, Network Providers, Subcontractors, and Downstream Subcontractors. Contractor must ensure Network Providers and Allied Health Personnel receive pertinent information regarding the PNA findings and the identified targeted strategies. Contractor must use the most appropriate communication method(s) to assure the information can be accessed and understood. The training must include the following requirements:

1) Promote access and delivery of services in a culturally competent manner to all Members and Potential Members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56; and

2) Information about the Health Inequities and identified cultural groups in Contractor's Service Area which includes but is not limited to: the groups' beliefs about illness and health; need for gender affirming care; methods of interacting with Providers and the health care structure; traditional home remedies that may

impact what the Provider recommends to treat the patient; and language and literacy needs.

D. Community Engagement

Contractor must develop a policy and procedure for a Member and family engagement strategy that involves Members and their families as partners in the delivery of Covered Services. This includes, but is not limited to the following:

1) Maintaining an organizational leadership commitment to engaging with Members and their families in the delivery of care;

2) Routinely engaging with Members and families through focus groups, listening sessions, surveys and/or interviews and incorporating results into policies and decision-making, as described in Exhibit A, Attachment III, Subsection 2.2.7.A (*Quality Improvement and Health Equity Annual Plan*);

3) Developing processes and accountability for incorporating Member and family input into policies and decision-making;

4) Developing processes to measures and/or monitor the impact of Member and family input into policies and decision-making;

5) Developing processes to share with Members and families how their input impacts policies and decision-making;

6) Conducting consumer surveys and incorporating results in Quality Improvement (QI) and Health Equity activities as described in Exhibit A, Attachment III, Subsection 2.2.9.C (*Consumer Satisfaction Survey*);

7) Partnering with community based organizations to cultivate Member and family engagement;

8) Maintaining a CAC whose composition reflects Contractor's Member population and whose input is actively utilized in policies and decision-making by Contractor, as outlined below in Exhibit A, Attachment III, Subsection 5.2.11.E. (*Cultural and Linguistic Programs and Committees*).

E. Community Advisory Committee (CAC)

1) Contractor must have a diverse CAC pursuant to 22 CCR section 53876(c), comprised primarily of Contractor's Members, as part of Contractor's implementation and maintenance of Member and community engagement with stakeholders, community advocates, traditional and Safety-Net Providers, and Members.

2) CAC Membership

   a) Contractor must convene a CAC selection committee tasked with selecting the members of the CAC. Contractor must demonstrate a good faith effort to ensure that the CAC selection committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the CAC:

      i. Persons who sit on Contractor's Governing Board, which should include representation in the following areas: Safety Net Providers including FQHCs, Behavioral Health Providers, Regional Centers (RC), Local Education Agencies (LEAs), dental Providers, IHCPs, and Home and Community-Based Service (HCBS) program Providers; and

      ii. Persons and community-based organizations who are representatives of each county within Contractor's Service Area adjusting for changes in membership diversity.

   b) The CAC selection committee must ensure the CAC membership reflects the general Medi-Cal Member population in Contractor's Service Area, including representatives from IHCPs, and adolescents and/or parents and/or caregivers of Children, including foster youth, as appropriate and be modified as the population changes to ensure that Contractor's community is represented and engaged. The CAC selection committee must make good faith efforts to include representatives from diverse and hard-to-reach populations on the CAC, with a specific emphasis on persons who are representative of or serving populations that experience Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.

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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

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be a member of the CAC or a Member enrolled with Contractor.

3) CAC Meetings

a) Contractor must hold its first regular CAC meeting promptly after all initial CAC members have been selected by the CAC selection committee and at least quarterly thereafter.

b) Contractor must make the regularly scheduled CAC meetings open to the public, posting meeting information publicly on Contractor's website in a centralized location 30 calendar days prior to the meeting, and in no event later than 72 hours prior to the meeting.

c) Contractor must provide a location for CAC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants and providing accommodations to allow all individuals to attend and participate in the meetings.

d) CAC must draft written minutes of each of its meetings and the associated discussions. All minutes must be posted on Contractor's website and submitted to DHCS no later than 45 calendar days after each meeting. Contractor must retain the minutes for no less than ten years and provided to DHCS, upon request.

e) Contractor must ensure that CAC members are supported in their roles on the CAC, including but not limited to providing resources to educate CAC members to ensure they are able to effectively participate in CAC meetings, providing transportation to CAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest CAC member participation possible.

f) Contractor must demonstrate that CAC input is considered in annual reviews and updates to relevant policies and procedures, including CAC input pursuant to Exhibit A, Attachment III, Subsection 5.2.11.E. (*Cultural and Linguistic Programs and Committees)* that is relevant to policies and procedures affecting quality and Health Equity. Contractor must provide a feedback loop to inform CAC members how their input has been incorporated.

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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.**~~The CAC must review PNA findings and have a process to discuss improvement opportunities with an emphasis on Health Equity and Social Drivers of Health. Contractor must allow its CAC to provide input on selecting targeted health education, cultural and linguistic, and QI strategies;~~

e) Contractor must provide sufficient resources for the CAC to support the required CAC activities outlined above, including supporting the CAC in engagement strategies such as consumer listening sessions, focus groups, and/or surveys; and

f) The CAC must provide input and advice, including, but not limited to, the following:

i. Culturally appropriate service or program design;

ii. Priorities for health education and outreach program;

iii. Member satisfaction survey results;

iv. Findings of the PNA;

v. Plan Marketing Materials and campaigns.

vi. Communication of needs for Network development and assessment;

vii. Community resources and information;

viii. Population Health Management;

ix. Quality;

x. Health Delivery Systems Reforms to improve health outcomes;

xi. Carved Out Services;

xii. Coordination of Care; and

xiii. Health Equity;

xiv. Accessibility of Services

5) Contractor's Annual CAC Demographic Report

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;

c) The data sources relied upon by Contractor to validate that its CAC membership aligns with Contractor's Member demographics;

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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 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.

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

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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;

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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.

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b) Arrange for a referral to, and a facilitation of, in-person care that does not require a Member to independently contact a different Provider to arrange for that care.

5) Contractor is responsible for ensuring Members are informed prior to the initial delivery of Covered Services via Telehealth about the use of Telehealth. Contractor must also ensure Providers obtain and document verbal or written consent from Members for the use of Telehealth as an acceptable mode of delivering services prior to the initial delivery of Covered Services. Consent must be documented in the Member's Medical Record and made available to DHCS upon request.

6) Contractor must communicate to Providers any periodical updates to Covered Services and Provider types and requirements that may be appropriately delivered through Telehealth.

5.3.2 Medically Necessary Services

Contractor must apply the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity for Members less than 21 years of age, as set forth in 42 USC section 1396d(r)(5) and All Plan Letter (APL) 23-005. The terms Medically Necessary, or Medical Necessity, are defined in Exhibit A, Attachment I, Article 1.0 (*Definitions*), based upon whether a Member is less than 21 years of age, or ages 21 and over.

5.3.3 Initial Health Appointment

Contractor must ensure provision of an Initial Health Appointment (IHA) in accordance with 22 California Code of Regulations (CCR) sections 53851(b)(1), 53910.5(a)(1) and APL 22-030. An IHA at a minimum must include: a history of the Member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, a physical examination, and the diagnosis and plan for treatment of any diseases, unless the Member's Primary Care Provider (PCP) determines that the Member's Medical Record contains complete information, updated within the previous 12 months, consistent with the assessment requirements. Contractor must continue to hold Network Providers accountable for providing all preventive screenings for adults and Children as recommended by the United States Preventive Services Taskforce (USPSTF) but will no longer require all of these elements to be completed during the IHA, so long as Members receive all required screenings in a timely manner consistent with USPSTF guidelines.

A. Contractor must cover and ensure the provision of an IHA for each new Member within timelines stipulated in Exhibit A, Attachment III, Subsections 5.3.4 (*Services for Members Less Than 21 Years of Age*) and 5.3.5 (*Services for Adults*) below.

B. Contractor must ensure that a Member's completed IHA is documented in their Medical Record and that appropriate assessments from the IHA are available during subsequent health visits.

C. Contractor must make reasonable attempts to contact a Member to schedule an IHA. Contractor must document all attempts to contact a Member. Documented attempts that demonstrate Contractor's efforts to unsuccessfully contact a Member and schedule an IHA will be considered evidence in meeting this requirement. Contractor may delegate these activities, but Contractor remains ultimately responsible for all delegated functions, as outlined in Exhibit A, Attachment III, Subsection 3.1.1 (*Overview of Contractor's Duties and Obligations*).

5.3.4 Services for Members Less Than 21 Years of Age

Contractor must cover and ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members less than 21 years of age required under the EPSDT benefit described in 42 USC section 1396d(r), W&I section 14132(v), and APL 23-005. The EPSDT benefit includes all Medically Necessary health care, diagnostic services, treatments, and other services listed in 42 USC section 1396d(a), whether or not covered under the California Medicaid State Plan. All EPSDT services are Covered Services unless expressly excluded under this Contract.

A. Provision of IHA for Members Less Than 21 Years of Age

1) For Members less than 18 months of age, Contractor must ensure the provision of an IHA within 120 calendar days following the date of Enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures for ages two and younger, whichever is sooner.

2) For Members ages 18 months and older, Contractor must ensure an IHA is performed within 120 calendar days of Enrollment.

3) The IHA must provide, or arrange for provision of, all immunizations necessary to ensure that the Member is up to date for their age, Adverse Childhood Experiences (ACEs) screening, and any

required age-specific screenings including developmental screenings.

4) If the provisions of the IHA are not met, then Contractor must ensure case management and Care Coordination are working directly with the Member to receive appropriate services to include but not limited to health screenings, immunizations, and risk assessments.

B. Children's Preventive Services

1) Contractor must provide preventive health visits for all Members less than 21 years of age at times specified by the most recent AAP Bright Futures Periodicity Schedule and anticipatory guidance as outlined in the AAP Bright Futures Periodicity Schedule. Contractor must provide, as part of the periodic preventive visit, all age-specific assessments and services required by AAP Bright Futures.

2) Where a request is made for Children's preventive services by the Member, the Member's parent, legal guardian, or Authorized Representatives (ARs), or through a referral, an appointment must be made for the Member to have a visit within ten Working Days of the request, unless Member declines a visit within ten Working Days of the request and another appointment date is chosen by the Member.

3) At each Non-emergency Primary Care visit with a Member less than 21 years of age, the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, must be advised of the Children's preventive services due and available from Contractor. Documentation must be entered in the Member's Medical Record which indicates the receipt of Children's preventive services in accordance with the AAP Bright Futures standards. If the services are refused, documentation must be entered in the Member's Medical Record which indicates the services were advised, and the Member's (if an emancipated minor), or the parent, legal guardian, or AR of the Member's voluntary refusal of these services.

4) All children's preventive services, including all confidential screening and billing reports for EPSDT screening, treatment, and Care Coordination, must be reported as part of the Encounter Data submittal required in Exhibit A, Attachment III, Subsection 2.1.2

(*Encounter Data Reporting*). Contractor must ensure appropriate acquisition for missed reporting of Children's preventive services.

C. Immunizations

1) Contractor must cover vaccinations, except for vaccinations expressly excluded in DHCS guidance to Medi-Cal Managed Care Health Plans, at the time of any health care visit and ensure the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by Advisory Committee on Immunization Practices (ACIP). Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the vaccination will be considered sufficient in meeting this requirement. When practical, reasons for failed attempts should be medically coded.

2) At each Non-Emergency Primary Care visit with Members less than 21 years of age, the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, must be advised of the vaccinations due and available from Contractor immediately, if the Member has not received vaccinations in accordance with ACIP standards. Documentation must be entered in the Member's Medical Record which indicates the receipt of vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation must be entered in the Member's Medical Record which indicates the vaccinations were advised, and the Member's (if an emancipated minor), or the parent, legal guardian, or AR of the Member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is required that the Medical Record must demonstrate that the Member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations.

3) Contractor must ensure that Member-specific vaccination information is reported to immunization registries established in Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports must be made following the Member's IHA and all other health care visits that result in an administered vaccine within 14 calendar days. Reporting must be in accordance with all applicable State and federal laws.

4) Within 30 calendar days of Federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization

purposes, Contractor must develop policies and procedures for the provision and administration of the vaccine. Contractor must cover and ensure the provision of the vaccine from the date of its approval regardless of whether or not the vaccine has been incorporated into the Vaccines for Children (VFC) Program. Policies and procedures must be in accordance with Medi-Cal guidelines issued prior to final ACIP recommendations.

5) Contractor must provide information to all Network Providers regarding the VFC Program and is encouraged to promote and support Enrollment of applicable Network Providers in the VFC program as see appropriate.

D. Screening for Childhood Lead Poisoning

1) Contractor must cover and ensure the provision of blood lead screening tests to Members at the ages and intervals specified in 17 CCR sections 37000 - 37100, and in accordance with APL 20-016. Contractor must ensure its Network Providers follow the Childhood Lead Poisoning Prevention Branch (CLPPB) guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including, without limitation, appropriate referrals to the local public health department.

a) While requirements for appropriate follow-up activities, including referral, case management, and reporting, are set forth in the CLPPB guidelines, a Network Provider may determine that additional services that fall within the EPSDT benefit are Medically Necessary.

b) Contractor must ensure that Members less than 21 years of age receive all Medically Necessary care as required under EPSDT.

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,

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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

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

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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.

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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

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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

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recurring appointments. Contractor cannot modify the form once the provider prescribes the mode of NEMT.

b) Contractor must refer and coordinate NEMT services for Medi-Cal services that are not covered under the Contract. However, Contractor must provide NEMT services for their Members for all pharmacy prescriptions prescribed by the Member's Medi-Cal provider(s) and those authorized under Medi-Cal Rx.

c) Contractor must have a process in place to ensure transportation brokers and providers are meeting these requirements and to impose corrective action if non-compliance is identified through oversight and monitoring activities.

3) As provided for in W&I section 14132(ad), Contractor must authorize all NMT for Members to obtain Covered Services in accordance with the requirements and guidelines set forth in APL 22-008. Nothing in this provision will be construed to prohibit Contractor from developing policies and procedures that may include reasonable ~~Prior Authorization requirements~~ **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

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b) Contractor is responsible for ensuring appropriate supervision of Dyadic Services Providers and educating all Network Providers on the Dyadic Services benefit.

2) Member Eligibility for Dyadic Services

a) Children and their parent(s)/ caregiver(s) are eligible for DBH well-Child visits when delivered according to the Bright Futures/American Academy of Pediatrics periodicity schedule for behavioral/social/emotional screening assessment, and when medically necessary, in accordance with Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards in 42 USC section 1396d(r).

i. Under EPSDT standards, a diagnosis is not required to qualify for services.

ii. The DBH well-Child visits do not need a particular recommendation or referral and must be offered as an appropriate service option even if the Member does not request them.

b) The family is eligible to receive Dyadic Services so long as the Child is enrolled in Medi-Cal. The parent(s) or caregiver(s) does not need to be enrolled in Medi-Cal or have other coverage so long as the care is for the direct benefit of the Child.

3) Covered Services

a) Contractor may offer the Dyadic Services benefit through Telehealth or in-person with locations in any setting including, but not limited to, pediatric Primary Care settings, doctor's offices or clinics, inpatient or outpatient settings in hospitals, the Member's home, school-based sites, or community settings. There are no Service Location limitations.

b) Covered Dyadic Services are Behavioral Health Services for Children and/or their parent(s) or caregiver(s), and include:

i. DBH Well-Child Visits

a. The DBH well-Child visit must be limited to those services not already covered in the medical well-Child visit.

b. When possible and operationally feasible, the DBH well-Child visit should occur on the same day as the medical well-Child visit. When this is not possible, Contractors must ensure the DBH well-Child visit is scheduled as close as possible to the medical well-Child visit, consistent with timely access requirements.

c. Contractor may deliver DBH well-Child visits as part of the HealthySteps program, a different DBH program, or in a clinical setting without a certified DBH program as long as all of the following components are included:

aa. Behavioral Health history for Child and parent(s) or caregiver(s), including parent(s) or caregiver(s) interview addressing Child's temperament, relationship with others, interests, abilities, and parent or caregiver concerns.

bb. Developmental history of the Child.

cc. Observation of behavior of Child and parent(s) or caregiver(s) and interaction between Child and parent(s) or caregiver(s).

dd. Mental status assessment of parent(s) or caregiver(s).

ee. Screening for family needs, which may include tobacco use, substance use, utility needs, transportation needs, and interpersonal safety, including guns in the home.

ff. Screening for SDOH such as poverty, food insecurity, housing instability, access to safe drinking water, and community level violence.

gg. Age-appropriate anticipatory guidance focused on Behavioral Health promotion/risk factor reduction.

hh. Making essential referrals and connections to community resources through Care Coordination and helping caregiver(s) prioritize needs.

ii. Dyadic Comprehensive Community Supports Services, separate and distinct from the California Advancing and Innovating Medi-Cal (CalAIM) Community Supports, help the Child and their parent(s) or caregiver(s) gain access to needed medical, social, educational, and other health-related services, and may include any of the following:

a. Assistance in maintaining, monitoring, and modifying covered services, as outlined in the dyad's service plan, to address an identified clinical need.

b. Brief telephone or face-to-face interactions with a person, family, or other involved member of the clinical team, for the purpose of offering assistance in accessing an identified clinical service.

c. Assistance in finding and connecting to necessary resources other than covered services to meet basic needs.

d. Communication and coordination of care with the Child's family, medical and dental health care Providers, community resources, and other involved supports including educational, social, judicial, community and other State agencies.

e. Outreach and follow-up of crisis contacts and missed appointments.

f. Other activities as needed to address the dyad's identified treatment and/or support needs.

c) Dyadic Psychoeducational Services for psychoeducational services provided to the Child less than 21 years of age and/or parent(s) or caregiver(s). These services must be planned, structured interventions that involve presenting or demonstrating information with the goal of preventing the development or worsening of Behavioral Health conditions and achieving optimal mental health and long-term resilience.

d) Dyadic Family Training and Counseling for Child Development for family training and counseling provided to both the Child less than 21 years of age and parent(s) or caregiver(s). These services include brief training and counseling related to a Child's behavioral issues, developmentally appropriate parenting strategies, parent/Child interactions, and other related issues.

e) Dyadic Parent or Caregiver Services

Dyadic parent or caregiver services are services delivered to a parent or caregiver during a Child's visit that is attended by the Child and parent or caregiver, including the following assessment, screening, counseling, and brief intervention services provided to the parent or caregiver for the benefit of the Child as appropriate:

i. Brief Emotional/Behavioral Assessment

ii. ACEs Screening

iii. Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment

iv. Depression Screening of Health Behavior Assessments and Interventions

v. Psychiatric Diagnostic Evaluation

vi. Tobacco Cessation Counseling

4) Family Therapy as a Behavioral Health Benefit

a) Family therapy is type of psychotherapy covered under Medi-Cal's NSMHS benefit, including for Members less than 21 years of age who are at risk for Behavioral Health concerns and for whom clinical literature would support that the risk is significant such that Family Therapy is indicated, but may not have a mental health diagnosis. The primary purpose of Family Therapy is to address family dynamics as they relate to the Member's mental status and behavior(s).

b) Family Therapy is composed of at least two family members receiving therapy together provided by a mental health Provider to improve parent/Child or caregiver/Child relationships and encourage bonding, resolving conflicts, and creating a positive home environment.

c) All family members do not need to be present for each service. For example, parents or caregivers can qualify for Family Therapy without their infant present, if necessary.

d) Both Children and adult Members can receive Family Therapy mental health services that are medically necessary. Contractor is required to provide Family Therapy to the following Medi-Cal Members to improve parent/Child or caregiver/Child relationships and bonding, resolve conflicts, and create a positive home environment:

i. Members less than 21 years of age with a diagnosis of a mental health disorder;

ii. Members less than 21 years of age with persistent mental health symptoms in the absence of a mental health disorder;

iii. Members less than 21 years of age with a history of at least one of the following risk factors:

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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

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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.

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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-

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home environmental trigger assessments for all Members with a diagnosis of asthma. APSs may be provided by a Physician or a Non-Physician Medical Practitioner, or a licensed practitioner of the healing arts within their scope of practice. APSs may also be provided by unlicensed Providers, which may include CHW, who have met the qualifications of an APS Provider and are providing these services under a supervising Physician or Non-Physician Medical Practitioner, clinic, hospital, local health jurisdiction, or community-based organization.

N. Community Health Workers Services

1) Contractor must ensure availability of CHW Services to all Members that meet the eligibility criteria in accordance with 42 CFR section 440.130(c).

2) Contractor must adhere to DHCS guidance on service definitions, eligible populations, and CHW Provider parameters as stated in APL 22-016.

a) CHW services are defined as preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs may include individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified below.

b) CHW services are considered Medically Necessary for Members with one or more chronic health conditions (including Behavioral Health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services.

3) CHW Provider and Supervising Provider Requirements

a) Contractor must determine, verify, and validate CHW Providers can provide CHW Services in an effective manner consistent with culturally and linguistically appropriate care.

b) CHW Providers must have lived experience that aligns with and provides a connection between CHW and the Member population being served in.

c) CHWs must have lived experience that aligns with and provides a connection between the CHW and the Member or population being served. This may include, but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

d) Contractor must contract with a Supervising Provider to oversee CHW providers and the services delivered to Members. CHW providers can be supervised by a community-based organization (CBO) or a local health jurisdiction (LHJ) that does not have a licensed Provider on staff in alignment with the Provider Manual and APL 22-016.

e) Contractor must ensure that Network Providers and Subcontractors contracting with or employing CHWs to provide Covered Services have adequate supervision and training.

f) Contractor must ensure CHW Providers demonstrate, and Supervisor Providers maintain evidence of, minimum qualifications through the CHW certificate pathway, Violence Prevention certificate pathway, or Work experience pathway.

g) Certificate Pathway: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates: o CHW Certificate: A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment,

professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and Social Drivers of Health (SDOH), as determined by the Supervising Provider. 6 Certificate programs must also include field experience as a requirement. A CHW Certificate allows a CHW to provide all covered CHW services described in this APL, including violence prevention services

h) Violence Prevention Professional Certificate: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training form the Urban Peace Institute. 7,8 A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or by completion of a General Certificate.

i) Work Experience Pathway: An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and has demonstrated skills and practical training in the areas described above, as determined and validated by the Supervising Provider, may provide CHW services without a certificate of completion for a maximum period of 18 months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Member.

j) Contractor must have a process for verifying qualifications and experience of Supervising Providers, which must extend to individuals employed by, or delivering CHW Services on behalf of, the Supervising Provider.

k) Contractor must ensure Supervising Providers and CHW Providers comply with all applicable State and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and PLs.

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;

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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

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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.** ~~Contractor must not deny, defer, or reduce a requested level of CBAS for a Member without a face-to-face review~~;

2) Develop and implement an expedited assessment process to determine CBAS eligibility within 72 hours of receipt of a CBAS authorization request for a Member in a hospital or Skilled Nursing Facility (SNF) whose discharge plan includes CBAS, or who is at high risk of admission to a hospital or SNF or faces an imminent and serious threat to their health;

3) Conduct a reassessment, with family involvement, when appropriate, and redetermination of the Member's eligibility for CBAS at least every six months after the initial assessment or up to every 12 months when determined by Contractor to be clinically appropriate. When a Member requests that services remain at the same level or requests an increase in services due to a change in their level of need, contractor may conduct the reassessment using only the Member's CBAS IPC, including any supporting documentation supplied by the CBAS Provider;

4) Notify Members in writing of their CBAS assessment determination in accordance with the timeframes identified in the CalAIM STCs, Section VIII.A.23.b.i. Contractor's written notice must be approved by DHCS and include procedures for Grievances and Appeals in accordance with current requirements identified in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

5) Require that CBAS Providers update a Member's CBAS Discharge Plan of Care and provide a copy to the Member and to Contractor whenever a Member's CBAS services are terminated. The CBAS Discharge Plan of Care must include:

   a) The Member's name and ID number;

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b) The name(s) of the Member's Physician(s);

c) If applicable, the date the Notice of Action denying authorization for CBAS was issued;

d) If applicable, the date the CBAS benefit will be terminated;

e) Specific information about the Member's current medical condition, treatments, and medications;

f) Potential referrals for Medically Necessary services and other services or community resources that the Member may need upon discharge;

g) Contact information for the Member's Case Manager; and

h) A space for the Member or the Member's representative to sign and date the Discharge Plan of Care.

D. Contractor must coordinate with the CBAS Provider to ensure the following:

1) CBAS IPCs are consistent with Members' overall care plans and goals developed by Contractor;

2) Timely exchange of the following coordination of care information: Member Discharge Plan of Care, reports of incidents that threaten the welfare, health and safety of the Member, and Significant Changes in the Member's condition;

3) Clear communication pathways between the appropriate CBAS Provider staff and Contractor staff responsible for CBAS eligibility determinations, service authorizations, and care planning, including identification of the lead care coordinator for Members who have a care team and Utilization Management; and

4) The CBAS Provider receives advance written notification and training prior to any substantive changes in Contractor's policies and procedures related to CBAS.

E. In addition to the requirements for unbundled CBAS contained in Exhibit A, Attachment III, Subsection 5.4.1 (*Covered Services*), and in accordance with Exhibit A, Attachment III, Subsection 5.4.2 (*Coordination of Care*),

Contractor must coordinate care for unbundled CBAS that are not Covered Services, based on the assessed needs of the Member eligible for CBAS, including:

1) Personal Care Services

2) Social Services

3) Physical and Occupational Maintenance Therapy

4) Meals

5) SMHS

6) SUD services that are not Covered Services.

5.4.3 Required Reports for the Community Based Adult Services Program

Contractor must submit to DHCS the following reports 30 calendar days following the end of each reporting period and in a format specified by DHCS:

A. How many Members have been assessed for CBAS and the total number of Members currently receiving CBAS, either as a bundled or unbundled service, on a quarterly basis;

B. Identification of CBAS Providers added to or deleted from Contractor's Network, and when there is a 5% drop in capacity, in the quarterly Network changes submission required in Exhibit A, Attachment III, Subsection 5.2.13.C. (*Network Reports*);

C. A summary of any complaints surrounding the provision of CBAS; and

D. Reports on the following areas:

1) Appeals related to requesting CBAS and the inability to receive those services or receiving more limited services than requested;

2) Appeals related to requesting a particular CBAS Provider and the inability to access that Provider;

3) Excessive travel times to access CBAS;

4) Grievances regarding CBAS Providers;

5) Grievances regarding Contractor assessment and/or reassessment; and

6) Any reports pertaining to the health and welfare of Members utilizing CBAS.

E. On an annual basis, Contractor must provide a list of its contracted CBAS Providers and its CBAS accessibility standards.

5.4.4. Community Participation

Contractor must ensure that engagement and community participation for Members receiving CBAS is supported to the fullest extent desired by each Member.

5.4.5. Community Based Adult Services Program Integrity

Following a determination that a credible allegation of Fraud exists involving a CBAS Provider, DHCS must notify Contractor of the finding promptly. In addition to the actions required in APL 15-026, Contractor must report to DHCS, in a timeframe and manner specified by DHCS but no less frequently than quarterly, all payments made to the CBAS Provider involved in a credible allegation of Fraud for CBAS benefits provided after the date of notification. DHCS may recoup payments from Contractor in accordance with CalAIM Terms and Conditions, GPR Section V.A.30.b.

Exhibit A, ATTACHMENT III

5.5 Mental Health and Substance Use Disorder Benefits

5.5.1 Mental Health Parity Requirements
5.5.2 Non-specialty Mental Health Services and Substance Use Disorder Services
5.5.3 Non-specialty Mental Health Services Providers
5.5.4 Emergency Mental Health and Substance Use Disorder Services
5.5.5 Mental Health and Substance Use Disorder Services Disputes
5.5.6 No Wrong Door for Mental Health Services

5.5 Mental Health and Substance Use Disorder Benefits

5.5.1 Mental Health Parity Requirements

Contractor must comply with all mental health parity requirements in 42 Code of Federal Regulations (CFR) section 438.900 *et seq*. Contractor must ensure it is not applying any financial or treatment limitation to mental health or Substance Use Disorder (SUD) benefits in any classification that is more restrictive than the predominant financial or treatment limitation applied to medical and surgical benefits in the same classification.

5.5.2 Non-specialty Mental Health Services and Substance Use Disorder Services

A. Non-specialty Mental Health Services (NSMHS) set forth in Welfare and Institutions Code (W&I) section 14189 are Covered Services in accordance with W&I section 14184.402, unless otherwise specifically excluded under the terms of this Contract. Contractor must consider equity in the provision of such services.

B. Contractor must cover NSMHS including: individual and group mental health evaluation and treatment, including psychotherapy, Family Therapy, and Dyadic Services; psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition; outpatient services for the purposes of monitoring drug therapy; psychiatric consultation; and outpatient laboratory, drugs, supplies, and supplements. Contractor must cover hypnotherapy, health behavior assessments and interventions, psychiatric collaborative care, and other NSMHS services described in the Medi-Cal Provider Manual as mental health evaluation and treatment NSMHS. Contractor must cover mental health screening services described in the Medi-Cal Provider Manual as NSMHS, including but not limited to adverse childhood experiences (ACE) screening, brief emotional/behavioral assessments, depression screening, general developmental screening, autism spectrum disorder screening, and other screening services in accordance with Exhibit A, Attachment III, Subsection 5.5.2.F. (*Non-specialty Mental Health Services and Substance Use Disorder Services*). Contractor must cover SUD services including: drug and alcohol Screening, Brief Intervention and Referral to Treatment (SBIRT) services; tobacco cessation counseling; medications for addiction treatment (also known as medication-assisted treatment or MAT) when delivered in Primary Care offices, emergency departments, inpatient hospitals, and other contracted medical settings; and Medically Necessary Behavioral Health Services. Covered NSMHS and SUD Services can be

delivered in person and via Telehealth/telephone as specified in Exhibit A, Attachment III, Subsection 5.3.1 (*Covered Services*).

C. If a Member is receiving NSMHS and is determined to meet the criteria for Specialty Mental Health Services (SMHS) as defined by W&I section 14184.402, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-specialty Mental Health Services and Substance Use Disorder Services*) as required when Members who have established relationships with contracted mental health Providers experience a change in condition requiring SMHS. Likewise, if a Member is receiving SMHS and is determined to meet the criteria for NSMHS as defined by W&I section 14184.402, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-specialty Mental Health Services and Substance Use Disorder Services*) as required when Members who have established relationships with SMHS Providers experience a change in condition requiring NSMHS. Contractor must continue to cover the provision of NSMHS provided to a Member concurrently receiving SMHS when those services are not duplicative and provide coordination of care with the County Mental Health Plan (MHP) in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-specialty Mental Health Services and Substance Use Disorder Services*). This provision does not preclude coverage of Behavioral Health Services that are within the scope of practice of licensed mental health care Primary Care Providers (PCPs) and mental health care Providers in accordance with All Plan Letter (APL) 22-006 and APL15-008.

D. For Members ages 21 and over who meet the criteria for NSMHS set forth in the W&I section 14184.402(b)(2), Contractor must cover NSMHS that are Medically Necessary Covered Services in accordance with W&I section 14059.5. For Members ages 21 and over, Contractor must cover SUD services that are Medically Necessary Covered Services in accordance with W&I section 14059.5. Contractor's coverage of NSMHS and SUD services must comply with W&I section 14184.402(f).

E. For Members less than 21 years of age, Contractor must cover NSMHS that are Medically Necessary Covered Services in accordance with W&I section 14184.402(b)(2). For Members less than 21 years of age, Contractor must cover SUD services that are Medically Necessary Covered Services. Medical Necessity determinations for NSMHS and SUD services must be made pursuant to W&I section 14059.5, and as required pursuant to 42 United States Code (USC) section 1396dI. For Members less than 21 years of age, NSMHS and Covered SUD services

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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.

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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

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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.

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.

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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:

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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

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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 ~~programs~~ **county commissions**;

~~4) Area Agencies on Aging (AAA); and~~

~~5) Caregiver Resource Center (CRC).~~

5.6.2 MOU Requirements

A. MOUs must contain all the following components, at a minimum:

1) Identification of services that are the responsibilities of each party under the MOU and the populations that are to be served;

2) Identification of the oversight responsibilities of each party, including the designation of a **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

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Behavioral Health and physical health data, maintaining the confidentiality of exchanged information and data, and obtaining Member consent;

6) Establishment of policies and procedures to address and document Quality Improvement (QI) activities for services covered under the MOU, including but not limited to, any applicable performance measures and QI initiatives, reports that track cross-system referrals, Member engagement, and service utilization;

7) Contractor must post on its website the date and time ~~of~~ the quarterly meeting 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;

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vi. Drug Medi-Cal; and

vii. Medically Necessary Covered Services for Members who are patients in psychiatric inpatient hospitals or IMDs.

f) A provision that states any decision rendered by DHCS regarding a dispute between Contractor and the MHP concerning provision of Covered Services is not subject to the dispute procedures specified in Exhibit E, Section 1.21 (*Contractor's Dispute Resolution Requirements*);

g) Policies and procedures to ensure Medically Necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative; and

h) Policies and procedures to ensure that Members meeting criteria for SMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred to the MHP in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*) and Exhibit A, Attachment III, Subsection 5.5.2 (*Non-specialty Mental Health Services and Substance Use Disorder Services*). Likewise, policies and procedures to ensure that Members meeting criteria for NSMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred by the MHP to Contractor in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*) and Exhibit A, Attachment III, Subsection 5.5.2 (*Non-specialty Mental Health Services and Substance Use Disorder Services*).

i) Contractor must report to DHCS updates from quarterly meetings in a manner and frequency specified by DHCS.

C. If Contractor reimburses the third-party entities or LGAs listed in Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) for services rendered, Contractor must execute a Network Provider Agreement, Subcontractor Agreement, and/or Downstream Subcontractor Agreement, as appropriate, in accordance with Exhibit A, Attachment III, Section 3.1

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(*Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties*).

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 ~~in the designated MOUs'~~ **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.

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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

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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

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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

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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

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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:

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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.

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3) Network Provider Agreements

a) Contractor's Network Provider Agreements must state that Network Providers are required to:

i. Annually submit evidence of adherence to Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Final Rule (FR), 81 FR 63859, and 84 FR 51732;

ii. Advise Contractor as part of the Network Provider's Emergency plan; and

iii. Notify Contractor within 24 hours of an Emergency if the Network Provider closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an Emergency.

6.1.4 California's Standardized Emergency Management System

A. Contractor must cooperate with local city and county Emergency Preparedness programs within Contractor's Service Area to ensure provision of health care services.

B. Contractor must, upon request, educate and prepare staff on the California State Emergency Plan and prepare staff to participate in California's Standardized Emergency Management System (SEMS).

C. Contractor must maintain contact information for local city and county Emergency Preparedness programs within Contractor's Service Area.

D. Contractor must ensure that its medical director and Grievance and Appeals coordinator are able to receive communications from the California Health Alert Network and the California State Warning Center.

6.1.5 Reporting Requirements During an Emergency

A. Within 24 hours of a federal, State, or county declared state of Emergency located within Contractor's Service Area, Contractor mustnotify DHCS as to whether Contractor has experienced or expects to experience any disruption to its operations.

B. At a minimum, Contractor must report the status of its operations once a day to DHCS, or as directed by DHCS.

C. Contractor's daily report to DHCS mustinclude, at a minimum, the following information:

1) The number of Members in Contractor's Service Area affected by the Emergency, per county, including the number of medium-to-high health risk Members, as identified through the Population Needs Assessment;

2) Information, to the extent available, relating to Network Provider site closures, including:

a) The number of Network Provider site closures by Provider type, per county;

b) The number of Members served by each closed Network Provider, per county;

c) The number of hospitalized Members who need to be transferred;

d) The location(s) of where Members were transferred; and

e) For each closed Network Provider, a list of the alternative Providers or facilities where Members can receive care.

3) The number of Contractor offices that are closed;

4) How Contractor is communicating with impacted Members, Network Providers, Subcontractors, and Downstream Subcontractors;

5) The actions Contractor has taken or will take to meet the continued health care needs of its Members; and

6) The Network Provider, Subcontractor, Downstream Subcontractor, or Member issues Contractor has received.

D. Contractor must comply with any guidance from the California Health and Human Services Agency regarding reporting on the status of Contractor's operations during an Emergency.

6.1.6 DHCS Emergency Directives

When a federal, State, or county Emergency is declared, Contractor agrees that DHCS may, in its sole discretion, waive existing contractual requirements and institute new contractual requirements to address an Emergency pursuant to an Emergency directive. DHCS Emergency directives do not require an amendment to this Contract prior to implementation. Emergency directives to Contractor may be communicated through All Plan Letters, advisory memos, or other similar announcements and are effective when published. Unless otherwise stated, Emergency directives will remain in effect until the Emergency directive is terminated. Contractor must promptly comply with all DHCS Emergency directives

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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**

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
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**
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

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0029	Non-Federally Qualified HMOs Subcontractor Agreement, Downstream Subcontractor Agreement, and Network Provider Amendment Approval Request	3.1.5	At least 30 calendar days before the effective date, unless otherwise instructed by DHCS Within 60 calendar days after the date the overpayment was identified.		DHCS
D.0030	Federally Qualified HMOs Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement	3.1.8	Upon DHCS request.		DHCS
D.0031	Termination Notice of Network Provider Agreement with a Safety-Net Provider	3.1.8	As needed, at least 60 calendar days prior to the effective date of termination or concurrently with the termination if Provider's license has been revoked or suspended or where the health and welfare of a Member is threatened.		DHCS
D.0118	Provider Selection	3.1.10	Upon request.		DHCS
D.0119	Delegation Model	3.1.12		On Contractor's website	

EXHIBIT A, ATTACHMENT III – 3.2 PROVIDER RELATIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0032	Provider Dispute Resolutions Report	3.2.2	Annually.		DHCS
D.0033	Most current Provider Manual	3.2.4	As needed. Annually.	Available to the Provider through Provider portals, the Internet or upon request.	Providers
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

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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** ~~shall have~~ no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Contract, and Contractor **is** ~~shall~~ not ~~be~~ obligated to perform any provisions of this Contract in any year when insufficient funding may occur. Further, should funding for any Fiscal Year be reduced or deleted by the Budget Act for purposes of this program, DHCS must have the option to:

1) Cancel this Contract with no liability accruing to DHCS and no further obligation by Contractor to perform hereunder; or

2) Offer a Contract amendment to Contractor to reflect the reduced amount of available funding.

B. All payments are subject to the availability of federal appropriation of Medicaid funding.

1.1.2 Contractor Risk

Except as otherwise specified in this Contract, Contractor will assume the total risk of providing Covered Services to Members on the basis of periodic Capitation Payments paid to Contractor by DHCS for each Member. Subject to Exhibit B, Section 1.1.15 (*Medical Loss Ratio Remittance*), any funds not expended by Contractor after having fulfilled all obligations under this Contract may be retained by Contractor.

1.1.3 Capitation Payment Rates

A. DHCS must remit to Contractor a Capitation Payment no later than 45 calendar days after the first day of each month for each Member that appears on the approved list of Members supplied to Contractor by DHCS. Capitation Payments must be made in accordance with the schedule of Capitation Payment rates set forth below. For the list of aid codes included in each Rate Group below, please see the definition of Potential Member

set forth in Exhibit A, Attachment I, Section 1.0 (*Definitions*) of this Contract. Supplemental and Additional Payments listed below will be made in accordance to the requirements stated in Subsections 1.1.7 (*Supplemental Payments*) and 1.1.8 (*Additional Payments*) of this Exhibit.

For the period 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.

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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

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** ~~shall be~~ effective as of January 1 of each year covered by this Contract;

2) In the event there is any delay in a determination or redetermination of Capitation Payment rates so that an amendment or change order may not be processed in sufficient time to permit payment of new rates commencing January 1, payment to Contractor 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

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c) Contractor must review all Contract Revenues and notify DHCS of any payment errors in a form and manner specified by DHCS. If the error favors DHCS, DHCS may offset against future Contract Revenues as stated in paragraph (b) above. If the error favors Contractor, Contractor must notify DHCS within 365 calendar days of payment, otherwise Contractor forfeits the right to receive the corrected payment, except when Contractor demonstrates to DHCS' satisfaction, in a form and manner specified by DHCS, that Contractor could not reasonably have identified the error.

4) If mutual agreement between DHCS and Contractor cannot be attained on Capitation Payment rates in accordance with this Paragraph B, Contractor ~~shall have~~ **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

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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.

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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

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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 ~~established in accordance with 42 CFR section 438.6(c),~~ in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each Directed Payment Initiative, including the Directed Payment Initiative preprint as applicable, available on the DHCS website at https://www.dhcs.ca.gov. Directed Payment Initiatives are

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subject to change ~~in accordance with the requirements of 42 CFR section 438.6(c),~~ and currently include:

1) Designated Public Hospital (DPH) Enhanced Payment Program (EPP), which requires Contractor to make uniform dollar or percentage increase payments to DPH systems for every qualifying service or assigned Member months in accordance with DHCS guidance, including but not limited to APL 21-018, the Directed Payment Initiative preprint, and W&I section 14197.4(b).

2) Private Hospital Directed Payments Program (PHDP), which requires Contractor to make uniform dollar increase payments to eligible private hospitals for every qualifying service in accordance with 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) Proposition 56 Directed Payments for Physician Services, which requires Contractor to make uniform dollar increase payments to~~

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~~eligible Network Providers for every adjudicated claim for specified physician services in accordance with DHCS guidance, including but not limited to APL 23-019 and the Directed Payment Initiative preprint.~~

7)~~8)~~ Directed Payments for Adverse Childhood Experiences (ACEs), which requires Contractor to pay eligible Network Providers at no less than the California Medicaid State Plan approved rates for every adjudicated claim for specified ACEs screening services in accordance with DHCS guidance, including but not limited to APL 23-017, ~~the Directed Payment Initiative preprint~~ and W&I section 14105.197(a)(4).

8)~~9)~~ Proposition 56 Directed Payments for Family Planning Services, which requires Contractor to make uniform dollar increase payments to eligible Providers for every adjudicated claim for specified family planning services in accordance with DHCS guidance, including but not limited to APL 23-008 and the Directed Payment Initiative preprint.

9)~~10)~~ 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)~~11)~~ LTC FFS-Equivalent Base Directed Payment, which requires Contractors to pay Network Providers, in specified counties where services were traditionally covered in the FFS delivery system, at exactly the California Medicaid State Plan approved case or service rates for Skilled Nursing Facility (SNF) services and Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N) services and Subacute (adult and pediatric) services . In all other counties, it requires Contractor~~s~~ to pay Network Providers at no less than the California Medicaid State Plan approved 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) ~~12)~~ Workforce Quality Incentive Program (WQIP), which requires Contractor to make uniform dollar increase payments to eligible Network Providers for every qualifying service adjusted based on DHCS' evaluation of their performance on specified quality and workforce measures in accordance with DHCS through APLs or other guidance, the Directed Payment Initiative preprint, and W&I section 14126.024.

12) ~~13)~~ In accordance with W&I section 5961.4(c), and for applicable dates of service, Contractor must reimburse Providers of Medically Necessary outpatient mental health or SUD treatment provided at a School Site to a Member who is a student 25 years of age or younger at least at the fee schedule rate or rates developed by the Department in accordance with W&I section 5961.4(a), as defined by DHCS in the California Medicaid State Plan, a Directed Payment Initiative, and other applicable guidance, but only to the extent Contractor is financially responsible for those School Site services under this Contract.

13) ~~14)~~ Equity and Practice Transformation Provider Directed Payment Program, which requires Contractor to pay performance-based quality incentive payments to Primary Care practices that provide pediatric, family medicine, internal medicine, or obstetrics and gynecology (OB/GYN) services 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) ~~15)~~ Targeted Rate Increases require Contractor to pay eligible Network Providers at no less than the California Medicaid State Plan approved rates for specified primary care services, including those provided by physician and non-physician professionals, obstetric services, including Doula services, and non-specialty mental health services, in accordance with W&I Section 14105.201, ~~any applicable Directed Payment Initiative Preprint~~, and in a form and

manner specified by DHCS through APL~~s~~ **24-007** 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.

1) 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.

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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 fa 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, 202**5**~~4.~~

A. The Risk Sharing Mechanism described in this provision may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through APLs or other technical guidance.

B. The Risk Sharing Mechanism will be symmetrical and based on the results of an Enhanced Care Management (ECM) risk corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal Managed Care contracts between Contractor and the State for those capitation increments, services, and populations associated with ECM, as determined by DHCS.

C. Contractor must provide and certify allowable medical expense data as necessary for the ECM risk corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance, and may be subject to audit by the State or its designee.

D. DHCS or its designee will initiate the ECM Risk Corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.

1.1.20 Federally Qualified Health Center Alternative Payment Model Risk Corridor

A Risk Sharing Mechanism will be in effect for each of the Rating Periods that the Federally Qualified Health Center (FQHC) Alternative Payment Model (APM) is in effect in accordance with W&I section 14138.16.

A. The Risk Sharing Mechanism described in this Subsection may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through APLs or other technical guidance.

B. The Risk Sharing Mechanism will be symmetrical and based on the results of an FQHC APM risk corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal managed care contracts between Contractor and the State for those capitation increments, services, and populations associated with the FQHC APM, as determined by DHCS.

C. Contractor must provide and certify allowable medical expense data as necessary for the FQHC APM risk corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance, and may be subject to audit by the State or its designee.

D. DHCS or its designee will initiate the FQHC APM Risk Corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.

1.1.21 Unsatisfactory Immigration Status Risk Corridor

A Risk Sharing Mechanism will be in effect for each of the Rating Periods covering dates of services from January 1, 2024, through December 31, 2024.

A. The Risk Sharing Mechanism described in this Subsection may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through APLs or other technical guidance.

B. The Risk Sharing Mechanism will be symmetrical and based on the results of an Unsatisfactory Immigration Status (UIS) risk corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal managed care contracts between Contractor and the State for those capitation increments, services, and populations associated with UIS, as determined by DHCS.

C. Contractor must provide and certify allowable medical expense data as necessary for the UIS risk corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance, and may be subject to audit by the State or its designee.

D. DHCS or its designee will initiate the UIS risk corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.

Exhibit C – General Terms and Conditions

The entire General Terms and Conditions (GTC 04/2017) developed by the California Department of General Services (DGS) ("Exhibit C") is not included in this Contract. Instead, applicable terms and provisions from Exhibit C have been incorporated throughout this Contract.

In the event that DGS amends Exhibit C after the effective date of the Contract, Contractor agrees that DHCS, in its sole discretion, may incorporate future DGS amendments into this Contract through the issuance of an All Plan Letter (APL) or other similar instructions.

Exhibit D(f) – Special Terms and Conditions

This is version (Rev. 10/22)

Exhibit D(f)

Special Terms and Conditions

(For federally funded service contracts or agreements and grant agreements)

The use of headings or titles throughout this exhibit is for convenience only and not be used to interpret or to govern the meaning of any specific term or condition.

The terms "contract", "Contractor" and "Subcontractor" shall also mean, “agreement”, "grant", “grant agreement”, "Grantee" and "Subgrantee" respectively.

The terms “California Department of Health Care Services”, “California Department of Health Services”, ‘Department of Health Care Services”, “Department of Health Services”, “CDHCS”, “DHCS”, “CDHS”, and “DHS” shall all have the same meaning and refer to the California State agency that is a party to this Agreement.

This exhibit contains provisions that require strict adherence to various contracting laws and policies. Some provisions herein are conditional and only apply if specified conditions exist (i.e., agreement total exceeds a certain amount; agreement is federally funded, etc.). The provisions herein apply to this Agreement unless the provisions are removed by reference on the face of this Agreement, the provisions are superseded by an alternate provision appearing elsewhere in this Agreement, or the applicable conditions do not exist.

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15. Documents, Publications, and Written Reports	34. Suspension or Stop Work Notification
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1. Federal Equal Opportunity Requirements

(Applicable to all federally funded agreements entered into by the Department of Health Care Services)

a. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices state the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

b. The Contractor will, in all solicitations or advancements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

c. The Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Contractor's commitments under the provisions herein and post copies of the notice in conspicuous places available to employees and applicants for employment.

d. The Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,‘ and as supplemented by regulation at 41 CFR part 60, “Office of the Federal Contract Compliance Programs, Equal Employment

Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

e. The Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

f. In the event of the Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further federal and State contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

g. The Contractor will include the provisions of Paragraphs a through g in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event the Contractor becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, the Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

(Applicable if travel and/or per diem expenses are reimbursed with agreement funds.)

Reimbursement for travel and per diem expenses from DHCS under this Agreement shall, unless otherwise specified in this Agreement, be at the rates currently in effect, as established by the California Department of Human Resources (CalHR), for nonrepresented State employees as stipulated in DHCS' Travel Reimbursement Information Exhibit. If the CalHR rates change during the term of the Agreement, the new rates apply upon their effective date and no amendment to this Agreement shall be necessary. Exceptions to CalHR rates may be approved by DHCS upon the submission of a statement by the Contractor indicating that such rates are not available to the Contractor. No travel outside the State of California shall be reimbursed without prior authorization from DHCS. Verbal authorization should be confirmed in writing. Written authorization may be in a form including fax or email confirmation.

3. Procurement Rules

(Applicable to agreements in which equipment/property, commodities and/or supplies are furnished by DHCS or expenses for said items are reimbursed by DHCS with State or federal funds provided under the Agreement.)

a. Equipment/Property definitions

Wherever the term equipment and/or property is used, the following definitions shall apply:

(1) **Major equipment/property**: A tangible or intangible item having a base unit cost of $5,000 or more with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement. Software and videos are examples of intangible items that meet this definition.

(2) **Minor equipment/property:** A tangible item having a base unit cost of less than $5,000 with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement.

b. Government and public entities (including State colleges/universities and auxiliary organizations), whether acting as a contractor and/or subcontractor, may secure all commodities, supplies, equipment and services related to such purchases that are required in performance of this Agreement. Said procurements are subject to Paragraphs d through h of Provision 3

c. Paragraph c of Provision 3 also apply, if equipment/property purchases are delegated to subcontractors that are nonprofit organizations or commercial businesses.

d. **Nonprofit organizations and commercial businesses,** whether acting as a contractor and/or subcontractor, may secure commodities, supplies, equipment/property and services related to such purchases for performance under this Agreement.

(1) Equipment/property purchases not exceed $50,000 annually.

To secure equipment/property above the annual maximum limit of $50,000, the Contractor make arrangements through the appropriate DHCS Program Contract Manager, to have all remaining equipment/property purchased through DHCS' Purchasing Unit. The cost of equipment/property purchased by or through DHCS be deducted from the funds available in this Agreement. Contractor submit to the DHCS Program Contract Manager a list of equipment/property specifications for those items that the State must procure. DHCS may pay the vendor directly for such arranged equipment/property purchases and title to the equipment/property will remain with DHCS. The equipment/property will be delivered to the Contractor's address, as stated on the face of the Agreement, unless the Contractor notifies the DHCS Program Contract Manager, in writing, of an alternate delivery address.

(2) All equipment/property purchases are subject to Paragraphs d through h of Provision 3. Paragraph b of Provision 3 also apply, if equipment/property purchases are delegated to Subcontractors that are either a government or public entity.

(3) Nonprofit organizations and commercial businesses use a procurement system that meets the following standards:

(a) Maintain a code or standard of conduct that govern the performance of its officers, employees, or agents engaged in awarding procurement contracts. No employee, officer, or agent shall participate in the selection, award, or administration of a procurement, or bid contract in which, to his or her knowledge, he or she has a financial interest.
(b) Procurements be conducted in a manner that provides, to the maximum extent practical, open, and free competition.

(c) Procurements be conducted in a manner that provides for all of the following:

[1] Avoid purchasing unnecessary or duplicate items.

[2] Equipment/property solicitations be based upon a clear and accurate description of the technical requirements of the goods to be procured.

[3] Take positive steps to utilize small and veteran owned businesses.

e. Unless waived or otherwise stipulated in writing by DHCS, prior written authorization from the appropriate DHCS Program Contract Manager will be

required before the Contractor will be reimbursed for any purchase of $5,000 or more for commodities, supplies, equipment/property, and services related to such purchases. The Contractor must provide in its request for authorization all particulars necessary, as specified by DHCS, for evaluating the necessity or desirability of incurring such costs. The term "purchase" excludes the purchase of services from a subcontractor and public utility services at rates established for uniform applicability to the general public.

f. In special circumstances, determined by DHCS (e.g., when DHCS has a need to monitor certain purchases, etc.), DHCS may require prior written authorization and/or the submission of paid vendor receipts for any purchase, regardless of dollar amount. DHCS reserves the right to either deny claims for reimbursement or to request repayment for any Contractor and/or subcontractor purchase that DHCS determines to be unnecessary in carrying out performance under this Agreement.

g. The Contractor and/or subcontractor must maintain a copy or narrative description of the procurement system, guidelines, rules, or regulations that will be used to make purchases under this Agreement. The State reserves the right to request a copy of these documents and to inspect the purchasing practices of the Contractor and/or subcontractor at any time.

h. For all purchases, the Contractor and/or subcontractor must maintain copies of all paid vendor invoices, documents, bids and other information used in vendor selection, for inspection or audit. Justifications supporting the absence of bidding (i.e., sole source purchases) also be maintained on file by the Contractor and/or subcontractor for inspection or audit.

i. DHCS may, with cause (e.g., with reasonable suspicion of unnecessary purchases or use of inappropriate purchase practices, etc.), withhold, cancel, modify, or retract the delegated purchase authority granted under Paragraphs b and/or c of Provision 3 by giving the Contractor no less than 30 calendar days written notice.

4. Equipment/Property Ownership / Inventory / Disposition

(Applicable to agreements in which equipment/property is furnished by DHCS and/or when said items are purchased or reimbursed by DHCS with State or federal funds provided under the Agreement.)

a. Wherever the term equipment and/or property is used in Provision 4, the definitions in Paragraph a of Provision 3 apply.

Unless otherwise stipulated in this Agreement, all equipment and/or property that is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement be considered State equipment and the property of DHCS.

(1) **Reporting of Equipment/Property Receipt**

DHCS requires the reporting, tagging and annual inventorying of all equipment and/or property that is furnished by DHCS or purchased/reimbursed with funds provided through this Agreement.

Upon receipt of equipment and/or property, the Contractor report the receipt to the DHCS Program Contract Manager. To report the receipt of said items and to receive property tags, Contractor use a form or format designated by DHCS' Asset Management Unit. If the appropriate form (i.e., Contractor Equipment Purchased with DHCS Funds) does not accompany this Agreement, Contractor request a copy from the DHCS Program Contract Manager.

(2) **Annual Equipment/Property Inventory**

If the Contractor enters into an agreement with a term of more than twelve months, the Contractor submit an annual inventory of State equipment and/or property to the DHCS Program Contract Manager using a form or format designated by DHCS' Asset Management Unit. If an inventory report form (i.e., Inventory/Disposition of DHCS-Funded Equipment) does not accompany this Agreement, Contractor request a copy from the DHCS Program Contract Manager. Contractor:

(a) Include in the inventory report, equipment and/or property in the Contractor's possession and/or in the possession of a subcontractor (including independent consultants).

(b) Submit the inventory report to DHCS according to the instructions appearing on the inventory form or issued by the DHCS Program Contract Manager.

(c) Contact the DHCS Program Contract Manager to learn how to remove, trade-in, sell, transfer or survey off, from the inventory report, expired equipment and/or property that is no longer wanted, usable or has passed its life expectancy. Instructions will be supplied by either the DHCS Program Contract Manager or DHCS' Asset Management Unit.

b. Title to State equipment and/or property not be affected by its incorporation or attachment to any property not owned by the State.

c. Unless otherwise stipulated, DHCS be under no obligation to pay the cost of restoration, or rehabilitation of the Contractor's and/or Subcontractor's facility which may be affected by the removal of any State equipment and/or property.

d. The Contractor and/or Subcontractor maintain and administer a sound business program for ensuring the proper use, maintenance, repair, protection, insurance and preservation of State equipment and/or property.

(1) In administering this provision, DHCS may require the Contractor and/or Subcontractor to repair or replace, to DHCS' satisfaction, any damaged, lost

or stolen State equipment and/or property. In the event of State equipment and/or miscellaneous property theft, Contractor and/or Subcontractor immediately file a theft report with the appropriate police agency or the California Highway Patrol and Contractor promptly submit one copy of the theft report to the DHCS Program Contract Manager.

e. Unless otherwise stipulated by the Program funding this Agreement, equipment and/or property purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, only be used for performance of this Agreement or another DHCS agreement.

Within sixty (60) calendar days prior to the termination or end of this Agreement, the Contractor provide a final inventory report of equipment and/or property to the DHCS Program Contract Manager and, at that time, query DHCS as to the requirements, including the manner and method, of returning State equipment and/or property to DHCS. Final disposition of equipment and/or property be at DHCS expense and according to DHCS instructions. Equipment and/or property disposition instructions be issued by DHCS immediately after receipt of the final inventory report. At the termination or conclusion of this Agreement, DHCS may at its discretion, authorize the continued use of State equipment and/or property for performance of work under a different DHCS agreement.

f. **Motor Vehicles**

(Applicable only if motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under this Agreement.)

(1) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, within thirty (30) calendar days prior to the termination or end of this Agreement, the Contractor and/or Subcontractor return such vehicles to DHCS and deliver all necessary documents of title or registration to enable the proper transfer of a marketable title to DHCS.

(2) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the State of California be the legal owner of said motor vehicles and the Contractor be the registered owner. The Contractor and/or a subcontractor may only use said vehicles for performance and under the terms of this Agreement.

(3) The Contractor and/or Subcontractor agree that all operators of motor vehicles, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, hold a valid State of California driver's license. In the event that ten or more passengers are to be transported in any one vehicle, the operator also hold a State of California Class B driver's license.

(4) If any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the Contractor and/or Subcontractor, as applicable, provide, maintain, and certify that, at a minimum, the following type and amount of automobile liability insurance is in effect during the term of this Agreement or any extension period during which any vehicle remains in the Contractor's and/or Subcontractor's possession:

Automobile Liability Insurance

(a) The Contractor, by signing this Agreement, hereby certifies that it possesses or will obtain automobile liability insurance in the amount of $1,000,000 per occurrence for bodily injury and property damage combined. Said insurance must be obtained and made effective upon the delivery date of any motor vehicle, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, to the Contractor and/or Subcontractor.

(b) The Contractor and/or Subcontractor, as soon as practical, furnish a copy of the certificate of insurance to the DHCS Program Contract Manager. The certificate of insurance identify the DHCS contract or agreement number for which the insurance applies.

(c) The 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 returned to DHCS.

(d) The Contractor and/or Subcontractor agree to provide, at least thirty (30) days prior to the expiration date of said insurance coverage, a copy of a new certificate of insurance evidencing continued coverage, as indicated herein, for not less than the remainder of the term of this Agreement, the term of any extension or continuation thereof, or for a period of not less than one (1) year.

(e) The Contractor and/or Subcontractor, if not a self-insured government and/or public entity, must provide evidence, that any required certificates of insurance contain the following provisions:

[1] The insurer will not cancel the insured's coverage without giving thirty (30) calendar days prior written notice to the State (California Department of Health Care Services).

[2] The State of California, its officers, agents, employees, and servants are included as additional insureds, but only with respect to work performed for the State under this Agreement and any extension or continuation of this Agreement.

[3] The insurance carrier notify the California Department of Health Care

Services (DHCS), in writing, of the Contractor's failure to pay premiums; its cancellation of such policies; or any other substantial change, including, but not limited to, the status, coverage, or scope of the required insurance. Such notices contain a reference to each agreement number for which the insurance was obtained.

(f) The Contractor and/or Subcontractor is hereby advised that copies of certificates of insurance may be subject to review and approval by the Department of General Services (DGS), Office of Risk and Insurance Management. The Contractor be notified by DHCS, in writing, if this provision is applicable to this Agreement. If DGS approval of the certificate of insurance is required, the Contractor agrees that no work or services shall be performed prior to obtaining said approval.

(g) In the event the Contractor and/or Subcontractor fails to keep insurance coverage, as required herein, in effect at all times during vehicle possession, DHCS may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

5. Subcontract Requirements

(Applicable to agreements under which services are to be performed by subcontractors including independent consultants.)

a. Prior written authorization will be required before the Contractor enters into or is reimbursed for any subcontract for services costing $5,000 or more. Except as indicated in Paragraph a(3) herein, when securing subcontracts for services exceeding $5,000, the Contractor obtain at least three bids or justify a sole source award.

(1) The Contractor must provide in its request for authorization, all information necessary for evaluating the necessity or desirability of incurring such cost.

(2) DHCS may identify the information needed to fulfill this requirement.

(3) Subcontracts performed by the following entities or for the service types listed below are exempt from the bidding and sole source justification requirements:

(a) A local governmental entity or the federal government,

(b) A State college or State university from any State,

(c) A Joint Powers Authority,

(d) An auxiliary organization of a California State University or a California community college,

(e) A foundation organized to support the Board of Governors of the California Community Colleges,

(f) An auxiliary organization of the Student Aid Commission established under Education Code § 69522,

(g) Firms or individuals proposed for use and approved by DHCS' funding Program via acceptance of an application or proposal for funding or pre/post contract award negotiations,

(h) Entities and/or service types identified as exempt from advertising and competitive bidding in State Contracting Manual Chapter 5 Section 5.80 Subsection B.2.

b. DHCS reserves the right to approve or disapprove the selection of subcontractors and with advance written notice, require the substitution of subcontractors and require the Contractor to terminate subcontracts entered into in support of this Agreement.

(1) Upon receipt of a written notice from DHCS requiring the substitution and/or termination of a subcontract, the Contractor take steps to ensure the completion of any work in progress and select a replacement, if applicable, within 30 calendar days, unless a longer period is agreed to by DHCS.

c. Actual subcontracts (i.e., written agreement between the Contractor and a subcontractor) of $5,000 or more are subject to the prior review and written approval of DHCS. DHCS may, at its discretion, elect to waive this right. All such waivers be confirmed in writing by DHCS.

d. Contractor maintain a copy of each subcontract entered into in support of this Agreement and, upon request by DHCS, make copies available for approval, inspection, or audit.

e. DHCS assumes no responsibility for the payment of subcontractors used in the performance of this Agreement. Contractor accepts sole responsibility for the payment of subcontractors used in the performance of this Agreement.

f. The Contractor is responsible for all performance requirements under this Agreement even though performance may be carried out through a subcontract.

g. The Contractor ensure that all subcontracts for services include provision(s) requiring compliance with applicable terms and conditions specified in this Agreement.

h. The Contractor agrees to include the following clause, relevant to record retention, in all subcontracts for services:

"(Subcontractor Name) agrees to maintain and preserve, until three years after termination of (Agreement Number) and final payment from DHCS to the Contractor, to permit DHCS or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers and records

related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records."

i. Unless otherwise stipulated in writing by DHCS, the Contractor be the subcontractor's sole point of contact for all matters related to performance and payment under this Agreement.

j. Contractor, as applicable, advise all subcontractors of their obligations pursuant to the following numbered provisions of this Exhibit: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 17, 19, 20, 24, 32 and/or other numbered provisions herein that are deemed applicable.

6. Income Restrictions

Unless otherwise stipulated in this Agreement, the Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this Agreement be paid by the Contractor to DHCS, to the extent that they are properly allocable to costs for which the Contractor has been reimbursed by DHCS under this Agreement.

7. Audit and Record Retention

(Applicable to agreements in excess of $10,000.)

a. The Contractor and/or Subcontractor maintain books, records, documents, and other evidence, accounting procedures and practices, sufficient to properly reflect all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Agreement, including any matching costs and expenses. The foregoing constitutes "records" for the purpose of this provision.

b. The Contractor's and/or subcontractor's facility or office or such part thereof as may be engaged in the performance of this Agreement and his/her records be subject at all reasonable times to inspection, audit, and reproduction.

c. Contractor agrees that DHCS, the Department of General Services, the Bureau of State Audits, or their designated representatives including the Comptroller General of the United States have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, the Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement. (Government Code Section 8546.7, Public Contract Code (PCC) Sections 10115 et seq., Code of California Regulations Title 2, Section 1896.77.) The Contractor comply with the above and be aware of the penalties for violations of fraud and for obstruction of investigation as set forth in PCC Section10115.10.

d. The Contractor and/or Subcontractor preserve and make available his/her records (1) for a period of six years for all records related to Disabled Veteran Business Enterprise (DVBE) participation (Military and Veterans Code 999.55), if this Agreement involves DVBE participation, and three years for all other contract records from the date of final payment under this Agreement, and (2) for such longer period, if any, as is required by applicable statute, by any other provision of this Agreement, or by subparagraphs (1) or (2) below.

   (1) If this Agreement is completely or partially terminated, the records relating to the work terminated be preserved and made available for a period of three years from the date of any resulting final settlement.

   (2) If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the three-year period, the records be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three-year period, whichever is later.

e. The Contractor and/or Subcontractor may, at its discretion, following receipt of final payment under this Agreement, reduce its accounts, books and records related to this Agreement to microfilm, computer disk, CD ROM, DVD, or other data storage medium. Upon request by an authorized representative to inspect, audit or obtain copies of said records, the Contractor and/or Subcontractor must supply or make available applicable devices, hardware, and/or software necessary to view, copy and/or print said records. Applicable devices may include, but are not limited to, microfilm readers and microfilm printers, etc.

f. The Contractor, if applicable, comply with the Single Audit Act and the audit requirements set forth in 2 C.F.R. § 200.501 (2014).

8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract supported activities and the premises in which it is being performed. If any inspection or evaluation is made of the premises of the Contractor or Subcontractor, the Contractor provide and require Subcontractors to provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations be performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

(Applicable only to that portion of an agreement funded in part or whole with federal funds.)

a. It is mutually understood between the parties that this Agreement may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal

delays which would occur if the Agreement were executed after that determination was made.

b. This agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or funding of this Agreement in any manner.

c. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this Agreement be amended to reflect any reduction in funds.

d. DHCS has the option to invalidate or cancel the Agreement with 30-days advance written notice or to amend the Agreement to reflect any reduction in funds.

10. Termination

a. **For Cause**

The State may terminate this Agreement, in whole or in part, and be relieved of any payments should the Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided. In the event of such termination, the State may proceed with the work in any manner deemed proper by the State. All costs to the State be deducted from any sum due the Contractor under this Agreement and the balance, if any, be paid to the Contractor upon demand. If this Agreement is terminated, in whole or in part, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials, related to the terminated portion of the Contract, including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The State pay contract price for completed deliverables delivered and accepted and items the State requires the Contractor to transfer as described in this paragraph above.

b. **For Convenience**

The State retains the option to terminate this Agreement, in whole or in part, without cause, at the State's convenience, without penalty, provided that written notice has been delivered to the Contractor at least ninety (90) calendar days prior to such termination date. In the event of termination, in whole or in part, under this paragraph, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials related to

the terminated portion of the contract including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The Contractor will be entitled to compensation upon submission of an invoice and proper proof of claim for the services and products satisfactorily rendered, subject to all payment provisions of the Agreement. Payment is limited to expenses necessarily incurred pursuant to this Agreement up to the date of termination.

11. Intellectual Property Rights

a. **Ownership**

(1) Except where DHCS has agreed in a signed writing to accept a license, DHCS be and remain, without additional compensation, the sole owner of any and all rights, title and interest in all Intellectual Property, from the moment of creation, whether or not jointly conceived, that are made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

(2) For the purposes of this Agreement, Intellectual Property means recognized protectable rights and interest such as: patents, (whether or not issued) copyrights, trademarks, service marks, applications for any of the foregoing, inventions, trade secrets, trade dress, logos, insignia, color combinations, slogans, moral rights, right of publicity, author's rights, contract and licensing rights, works, mask works, industrial design rights, rights of priority, know how, design flows, methodologies, devices, business processes, developments, innovations, good will and all other legal rights protecting intangible proprietary information as may exist now and/or here after come into existence, and all renewals and extensions, regardless of whether those rights arise under the laws of the United States, or any other state, country or jurisdiction.

(a) For the purposes of the definition of Intellectual Property, "works" means all literary works, writings and printed matter including the medium by which they are recorded or reproduced, photographs, art work, pictorial and graphic representations and works of a similar nature, film, motion pictures, digital images, animation cells, and other audiovisual works including positives and negatives thereof, sound recordings, tapes, educational materials, interactive videos and any other materials or products created, produced, conceptualized and fixed in a tangible medium of expression. It includes preliminary and final products and any materials and information developed for the purposes of producing those final products. Works does not include articles submitted to peer review or reference journals or independent research projects.

(3) In the performance of this Agreement, Contractor will exercise and utilize certain of its Intellectual Property in existence prior to the effective date of this Agreement. In addition, under this Agreement, Contractor may access and utilize certain of DHCS' Intellectual Property in existence prior to the effective date of this Agreement. Except as otherwise set forth herein, Contractor not use any of DHCS' Intellectual Property now existing or hereafter existing for any purposes without the prior written permission of DHCS. Except as otherwise set forth herein, neither the Contractor nor DHCS give any ownership interest in or rights to its Intellectual Property to the other Party. If during the term of this Agreement, Contractor accesses any third-party Intellectual Property that is licensed to DHCS, Contractor agrees to abide by all license and confidentiality restrictions applicable to DHCS in the third-party's license agreement.

(4) Contractor agrees to cooperate with DHCS in establishing or maintaining DHCS' exclusive rights in the Intellectual Property, and in assuring DHCS' sole rights against third parties with respect to the Intellectual Property. If the Contractor enters into any agreements or subcontracts with other parties in order to perform this Agreement, Contractor require the terms of the Agreement(s) to include all Intellectual Property provisions. Such terms must include, but are not limited to, the subcontractor assigning and agreeing to assign to DHCS all rights, title and interest in Intellectual Property made, conceived, derived from, or reduced to practice by the subcontractor, Contractor or DHCS and which result directly or indirectly from this Agreement or any subcontract.

(5) Contractor further agrees to assist and cooperate with DHCS in all reasonable respects, and execute all documents and, subject to reasonable availability, give testimony and take all further acts reasonably necessary to acquire, transfer, maintain, and enforce DHCS' Intellectual Property rights and interests.

b. **Retained Rights / License Rights**

(1) Except for Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, Contractor retain title to all of its Intellectual Property to the extent such Intellectual Property is in existence prior to the effective date of this Agreement. Contractor hereby grants to DHCS, without additional compensation, a permanent, non-exclusive, royalty free, paid-up, worldwide, irrevocable, perpetual, non-terminable license to use, reproduce, manufacture, sell, offer to sell, import, export, modify, publicly and privately display/perform, distribute, and dispose Contractor's Intellectual Property with the right to sublicense through multiple layers, for any purpose whatsoever, to the extent it is incorporated in the Intellectual Property resulting from this Agreement, unless Contractor assigns all rights, title and interest in the Intellectual Property as set forth herein.

(2) Nothing in this provision shall restrict, limit, or otherwise prevent Contractor from using any ideas, concepts, know-how, methodology or techniques related to its performance under this Agreement, provided that Contractor's use does not infringe the patent, copyright, trademark rights, license or other Intellectual Property rights of DHCS or third party, or result in a breach or default of any provisions of this Exhibit or result in a breach of any provisions of law relating to confidentiality.

c. **Copyright**

(1) Contractor agrees that for purposes of copyright law, all works [as defined in Paragraph a, subparagraph (2)(a) of this provision] of authorship made by or on behalf of Contractor in connection with Contractor's performance of this Agreement be deemed "works made for hire". Contractor further agrees that the work of each person utilized by Contractor in connection with the performance of this Agreement will be a "work made for hire," whether that person is an employee of Contractor or that person has entered into an agreement with Contractor to perform the work. Contractor enter into a written agreement with any such person that: (i) all work performed for Contractor be deemed a "work made for hire" under the Copyright Act and (ii) that person assign all right, title, and interest to DHCS to any work product made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

(2) All materials, including, but not limited to, visual works or text, reproduced or distributed pursuant to this Agreement that include Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, include DHCS' notice of copyright, which read in 3mm or larger typeface: "© [Enter Current Year e.g., 2010, etc.], California Department of Health Care Services. This material may not be reproduced or disseminated without prior written permission from the California Department of Health Care Services." This notice should be placed prominently on the materials and set apart from other matter on the page where it appears. Audio productions contain a similar audio notice of copyright.

d. **Patent Rights**

With respect to inventions made by Contractor in the performance of this Agreement, which did not result from research and development specifically included in the Agreement's scope of work, Contractor hereby grants to DHCS a license as described under Section b of this provision for devices or material incorporating, or made through the use of such inventions. If such inventions result from research and development work specifically included within the Agreement's scope of work, then Contractor agrees to assign to DHCS, without additional compensation, all its right, title and interest in and to such inventions and to assist DHCS in securing United States and foreign patents with respect thereto.

e. **Third-Party Intellectual Property**

Except as provided herein, Contractor agrees that its performance of this Agreement not be dependent upon or include any Intellectual Property of Contractor or third party without first: (i) obtaining DHCS' prior written approval; and (ii) granting to or obtaining for DHCS, without additional compensation, a license, as described in Section b of this provision, for any of Contractor's or third-party's Intellectual Property in existence prior to the effective date of this Agreement. If such a license upon ~~the~~ these terms is unattainable, and DHCS determines that the Intellectual Property should be included in or is required for Contractor's performance of this Agreement, Contractor obtain a license under terms acceptable to DHCS.

f. **Warranties**

(1) Contractor represents and warrants that:

(a) It is free to enter into and fully perform this Agreement.

(b) It has secured and will secure all rights and licenses necessary for its performance of this Agreement.

(c) Neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is currently no actual or threatened claim by any such thirdparty based on an alleged violation of any such right by Contractor.

(d) Neither Contractor's performance nor any part of its performance will violate the right of privacy of, or constitute a libel or slander against any person or entity.

(e) It has secured and will secure all rights and licenses necessary for Intellectual Property including, but not limited to, consents, waivers or releases from all authors of music or performances used, and talent (radio, television and motion picture talent), owners of any interest in and to real estate, sites, locations, property or props that may be used or shown.

(f) It has not granted and not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to DHCS in this Agreement.

(g) It has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

(h) It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this Agreement.

(2) DHCS makes no warranty that the intellectual property resulting from this agreement does not infringe upon any patent, trademark, copyright or the like, now existing or subsequently issued.

g. **Intellectual Property Indemnity**

(1) Contractor indemnify, defend and hold harmless DHCS and its licensees and assignees, and its officers, directors, employees, agents, representatives, successors, and users of its products, ("Indemnitees") from and against all claims, actions, damages, losses, liabilities (or actions or proceedings with respect to any thereof), whether or not rightful, arising from any and all actions or claims by any third party or expenses related thereto (including, but not limited to, all legal expenses, court costs, and attorney's fees incurred in investigating, preparing, serving as a witness in, or defending against, any such claim, action, or proceeding, commenced or threatened) to which any of the Indemnitees may be subject, whether or not Contractor is a party to any pending or threatened litigation, which arise out of or are related to (i) the incorrectness or breach of any of the representations, warranties, covenants or agreements of Contractor pertaining to Intellectual Property; or (ii) any Intellectual Property infringement, or any other type of actual or alleged infringement claim, arising out of DHCS' use, reproduction, manufacture, sale, offer to sell, distribution, import, export, modification, public and private performance/display, license, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement. This indemnity obligation apply irrespective of whether the infringement claim is based on a patent, trademark or copyright registration that issued after the effective date of this Agreement. DHCS reserves the right to participate in and/or control, at Contractor's expense, any such infringement action brought against DHCS.

(2) Should any Intellectual Property licensed by the Contractor to DHCS under this Agreement become the subject of an Intellectual Property infringement claim, Contractor will exercise its authority reasonably and in good faith to preserve DHCS' right to use the licensed Intellectual Property in accordance with this Agreement at no expense to DHCS. DHCS have the right to monitor and appear through its own counsel (at Contractor's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for DHCS to continue using the licensed Intellectual Property; or, replace or modify the licensed Intellectual Property so that the replaced or

modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property. If such remedies are not reasonably available, DHCS be entitled to a refund of all monies paid under this Agreement, without restriction or limitation of any other rights and remedies available at law or in equity.

(3) Contractor agrees that damages alone would be inadequate to compensate DHCS for breach of any term of this Intellectual Property Exhibit by Contractor. Contractor acknowledges DHCS would suffer irreparable harm in the event of such breach and agrees DHCS be entitled to obtain equitable relief, including without limitation an injunction, from a court of competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

h. **Federal Funding**

In any agreement funded in whole or in part by the federal government, DHCS may acquire and maintain the Intellectual Property rights, title, and ownership, which results directly or indirectly from the Agreement; except as provided in 37 Code of Federal Regulations part 401.14; however, the federal government shall have a non-exclusive, nontransferable, irrevocable, paid-up license throughout the world to use, duplicate, or dispose of such Intellectual Property throughout the world in any manner for governmental purposes and to have and permit others to do so.

i. **Survival**

The provisions set forth herein shall survive any termination or expiration of this Agreement or any project schedule.

12. Air or Water Pollution Requirements

Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt by law.

a. Government contractors agree to comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act (42 USC 7606) section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations.

b. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C. 7401 et seq.), as amended, and the Clean Water Act (33 U.S.C. 1251 et seq.), as amended.

13. Prior Approval of Training Seminars, Workshops or Conferences

Contractor obtain prior DHCS approval of the location, costs, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar, workshop, or conference conducted pursuant to this Agreement and of any reimbursable publicity or educational materials to be made available for distribution. The Contractor acknowledge the support of the State whenever publicizing the work under this Agreement in any media. This provision does not apply to necessary staff meetings or training sessions held for the staff of the Contractor or Subcontractor to conduct routine business matters.

14. Confidentiality of Information

a. The Contractor and its employees, agents, or subcontractors protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to the Contractor, its employees, agents, or subcontractors as a result of services performed under this Agreement, except for statistical information not identifying any such person.

b. The Contractor and its employees, agents, or subcontractors not use such identifying information for any purpose other than carrying out the Contractor's obligations under this Agreement.

c. The Contractor and its employees, agents, or subcontractors promptly transmit to the DHCS Program Contract Manager all requests for disclosure of such identifying information not emanating from the client or person.

d. The Contractor not disclose, except as otherwise specifically permitted by this Agreement or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS Program Contract Manager, except if disclosure is required by State or federal law.

e. For purposes of this provision, identity include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

f. As deemed applicable by DHCS, this provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this Agreement or incorporated into this Agreement by reference.

15. Documents, Publications and Written Reports

(Applicable to agreements over $5,000 under which publications, written reports and documents are developed or produced. Government Code Section 7550.)

Any document, publication or written report (excluding progress reports, financial reports and normal contractual communications) prepared as a requirement of this

Agreement contain, in a separate section preceding the main body of the document, the number and dollar amounts of all contracts or agreements and subcontracts relating to the preparation of such document or report, if the total cost for work by nonemployees of the State exceeds $5,000.

16. Dispute Resolution Process

a. A Contractor grievance exists whenever there is a dispute arising from DHCS' action in the administration of an agreement. If there is a dispute or grievance between the Contractor and DHCS, the Contractor must seek resolution using the procedure outlined below.

   (1) The Contractor should first informally discuss the problem with the DHCS Program Contract Manager. If the problem cannot be resolved informally, the Contractor direct its grievance together with any evidence, in writing, to the program Branch Chief. The grievance state the issues in dispute, the legal authority or other basis for the Contractor's position and the remedy sought. The Branch Chief render a decision within ten (10) **Working Days** after receipt of the written grievance from the Contractor. The Branch Chief respond in writing to the Contractor indicating the decision and reasons therefore. If the Contractor disagrees with the Branch Chief's decision, the Contractor may appeal to the second level.
   (2) When appealing to the second level, the Contractor must prepare an appeal indicating the reasons for disagreement with Branch Chief's decision. The Contractor **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**

(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** ~~t~~ 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 ~~w~~**Working** ~~d~~**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.

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):*

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person that fails to file the required disclosure shall be subject to a not more than $100,000 for each such failure.	
Signature:	
Print Name:	
Title:	
Telephone Number:	
Date:	
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form be completed by the reporting entity, whether subawardee or prime federal recipient, at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if itis, or expects to be,a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, state and zip code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001".

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).

11. The certifying official sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

Exhibit E – Program Terms and Conditions

1.0 Program Terms and Conditions

1.1 Program Terms and Conditions

1.1.1 Governing Law
1.1.2 DHCS Guidance
1.1.3 Contract Interpretation
1.1.4 Assignments, Mergers, Acquisitions
1.1.5 Independent Contractor
1.1.6 Amendment and Change Order Process
1.1.7 Delegation of Authority
1.1.8 Authority of the State
1.1.9 Fulfillment of Obligations
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1.1.27 Litigation Support
1.1.28 Equal Opportunity Employer
1.1.29 Federal and State Nondiscrimination Requirements
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1.1.31 Small Business Participation and Disabled Veteran Business Enterprises Reporting Requirements
1.1.32 Conflict of Interest Avoidance Requirements
1.1.33 Guaranty Provision
1.1.34 Priority of Provisions
1.1.35 Additional Incorporated Provisions – Narrative Proposals
1.1.36 Miscellaneous Provisions
1.1.37 Data Sharing

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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 ~~County State court~~.

D. Applicability of the Knox-Keene Act

1) A Contractor who is licensed as a health care service plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (KKA) (and its implementing regulations (~~22~~**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.

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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, S**ubs**ection **1.**1.3.A (~~*Conflict with Law*~~ ***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 ~~Changes~~ **Capitation Payments**

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DHCS may, at any time within the general scope of this Contract and by written notice, implement **Capitation Payment rates through** amendments ~~or issue change orders~~ to the Contract upon approval from CMS~~, as follows:~~.

~~1) Capitation Payment rates may be implemented through a change order if the rates are the only changes proposed by DHCS for a Rating Period.~~

~~2)~~ Capitation Payment rates that are ~~also~~ tied to proposed changes to the terms or requirements of the Contract effective within the Rating Period will be included in an amendment to the Contract.

D. Contractor's Obligation to Implement

Notwithstanding approval by CMS of proposed changes to this Contract, Contractor will comply with changes mandated by DHCS. In the case of changes mandated by regulations, statutes, federal guidelines, or judicial interpretation, Contractor must immediately begin implementation of any change proposed in an amendment to this Contract or through an APL. If DHCS implements an amendment~~, or issues a change order~~ or APL, Contractor must implement the required changes and accept current Capitation Payments as stated in Exhibit B, Section 1.5 (*Determination and Redetermination of Capitation Payment Rates*) while discussions relevant to any Capitation Payment rate adjustment, if applicable, are taking place.

1.1.7 Delegation of Authority

DHCS intends to implement this Contract through a single administrator, called the "DHCS Contracting Officer." The Director will appoint its DHCS Contracting Officer. The DHCS Contracting Officer, under the direction of the Director and on behalf of DHCS, will make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable federal and State laws and regulations. The DHCS Contracting Officer may delegate their authority to act to an authorized representative through written notice to Contractor.

Contractor will designate a single administrator (Contractor's Representative) to implement this Contract. Contractor's Representative, on behalf of Contractor, will make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of the Contract, federal and State laws and regulations. Contractor's Representative may delegate their authority to act to an AR through written notice to the DHCS Contracting Officer. Contractor's

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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

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Prior to commencement of operations, Contractor must obtain written approval from DHCS for all deliverables, including but not limited to protocols, policies, and procedures, set forth in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*).

B. DHCS Approval of Protocols, Policies, and Procedures

In addition to the deliverables identified in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) of this Contract, DHCS reserves the right to review and approve or disapprove Contractor's protocols, policies, and procedures. DHCS may, from time to time, request changes to Contractor's existing protocols, policies, and procedures. DHCS will issue such requests through APLs or other similar instructions. The deliverables, protocols, policies, and procedures referenced in this Exhibit E, Subsections 1.1.10.A and B (*Obtaining DHCS Approval*), will be subject to the DHCS approval process set forth in Exhibit E, Subsection 1.1.10.C (*Obtaining DHCS Approval*), below.

C. DHCS Approval Process

Within 60 calendar days of receipt, DHCS will make all reasonable efforts to approve in writing Contractor's deliverables, protocols, policies, and procedures; provide Contractor with a written explanation of disapproval; or provide a written estimated date of completion of DHCS' review process.

If DHCS does not complete its review of submitted materials within 60 calendar days of receipt, or within the estimated date of completion of DHCS review, Contractor may elect to implement or use the materials at Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This Exhibit E, Subsection 1.1.10.C (*Obtaining DHCS Approval*) will not be construed to imply DHCS approval of any materials that have not received written DHCS approval. This Section will not apply to Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements subject to DHCS approval in accordance with Exhibit A, Attachment III, Subsection 3.1.2 (*DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*).

1.1.11 Certifications

A. For each data submission required by 42 Code of Federal Regulations (CFR) section 438.604, Contractor must comply with the requirements of 42 CFR section 438.606 and APL 17-005. Contractor must submit its

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certification of compliance concurrently with the submission of its data, documentation or information pursuant to 42 CFR section 438.606(c). Contractor's certification(s) must be certified by Contractor's Chief Executive Officer (CEO); Chief Financial Officer (CFO); or an individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO. Contractor's CEO or CFO is solely responsible for the truth, accuracy and completeness of Contractor's certification.

1) Contractor's data submissions must be in a form and manner specified by DHCS:

   a) Encounter Data as set forth in 42 CFR section 438.604(a)(1); and

   b) Data used by the State to certify actuarial soundness of Capitation Payment rates as set forth in 42 CFR section 438.604(a)(2).

2) Medical Loss Ratio (MLR) data as set forth in 42 CFR section 438.604(a)(3);

3) Financial data regarding provisions against risk of insolvency as set forth in 42 CFR section 438.604(a)(4);

4) Documentation described in 42 CFR section 438.207(b) used to certify compliance with this Contract's requirements for accessibility and availability of services, including Network adequacy;

5) Contractor's information on ownership and control, including its Subcontractors, Downstream Subcontractors, and Network Providers, as set forth in 42 CFR sections 438.608(c)(2), 438.602(c), and 455.104;

6) The annual report of overpayment recoveries as required in 42 CFR section 438.608(d)(3);

7) Network Data as required in Exhibit A, Attachment III, Subsection 2.1.4 (*Network Provider Data Reporting*);

8) Documentation confirming compliance with this Contract's interoperability requirements and APL 22-026 that is certified by Contractor's CEO or CFO and in accordance with submission requirements in APL 17-005; and

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9) Any other data, documentation, or information requested by DHCS relating to the performance of Contractor's obligations under this Contract.

B. The Contractor Certification Clauses (CCC) contained in the Department of General Services form document CCC 04/2017 are hereby incorporated by reference and made a part of this Contract by this reference as if attached hereto.

1.1.12 Notices

All notices to be given under this Contract must be in writing and are deemed given when sent certified mailed or electronic mail (email) to DHCS or Contractor. DHCS and Contractor will designate email addresses for notices sent via email. Notices sent certified mail must be addressed to the following DHCS and Contractor addresses:

California Department of Health Care Services
Managed Care Operations Division
Attn: DHCS Contract Manager
MS 4407
P.O. Box 997413
Sacramento, CA 95899-7413

Orange County Health Authority, A Public Agency dba: CalOptima Health
Attn: Contractor Representative
505 City Parkway West
Orange, CA 92868

1.1.13 Term

A. The Contract will be effective January 1, 2024, and will continue in full force and effect through December 31, 2024, subject to Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*), CMS waiver approval, and Exhibit D(f), Section 9 (*Federal Contract Funds*).

B. If Contractor has not already commenced operations, the term of this Contract consists of the following three periods:

1) The Implementation Period;

2) The Operations Period; and

3) The Phaseout Period.

C. The Operations Period will commence at the conclusion of the Implementation Period, subject to DHCS acceptance of Contractor's readiness to begin the Operations Period. The term of the Operations Period is subject to the termination requirements of Exhibit E, Subsections

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1.1.16 (*Termination*) and 1.1.19, (*Sanctions*), and subject to the limitation provisions of Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*).

D. The Phaseout Period will commence on the date the Operations Period or Contract extension ends. The Phaseout Period will extend until all activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

E. If Contractor has commenced operations as of the effective date of this Contract, the term of the Contract consists of the Operations Period and the Phaseout Period. The term of the Operations Period is subject to the termination requirements of Exhibit E, Subsections 1.1.16 (*Termination*) and 1.1.19 (*Sanctions*) below and subject to the limitation requirements of Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*).

1.1.14 Service Area

The Service Area covered under this Contract includes:

Orange County

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

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a) DHCS must terminate this Contract in the event of any of the following:

i. The Secretary of the U.S. Department of Health & Human Services (U.S. DHHS) determines that Contractor does not meet the requirements for participation in the Medicaid program (42 United States Code (USC) section 1396);

ii. DMHC finds that Contractor no longer qualifies for licensure under the KKA (Health and Safety Code (H&S) section 1340 *et seq.*), if licensure is required; or

iii. The Director determines the health and welfare of Members is jeopardized by continuation of the Contract.

b) Termination pursuant to Subsection 1.16.A.1 (*Mandatory Termination*) will be effective immediately. Termination under this Section 1.16.A does not relieve Contractor of its obligations under Exhibit E, Section 1.17 (*Phaseout Requirements*).

2) Termination for Cause

a) DHCS may terminate this Contract and be relieved of any payments should Contractor fail to perform the requirements of this Contract. In the event of such termination, DHCS may proceed with providing the services required under this Contract in any manner deemed proper by DHCS. All costs to the State will be deducted from any sum due Contractor under this Contract and the balance, if any, will be paid to Contractor upon demand.

b) DHCS will provide Contractor with at least 60 calendar days' notice prior to the effective date of termination, unless Potential Member harm requires a shorter notice period. Contractor agrees that this notice provision is reasonable. Termination under this Subsection does not relieve Contractor of its obligations under Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

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c) DHCS will terminate this Contract under this Subsection, pursuant to the provisions of W&I section 14197.7 and 22 CCR section 53873.

d) Contractor may dispute termination decisions under this Exhibit E, Subsection 1.1.16 (*Termination*), through the dispute resolution process pursuant to Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*).

3) Permissive Termination

Following a merger or acquisition involving Contractor in which Contractor did not obtain DHCS' express written consent pursuant to Exhibit E, Subsection 1.1.4 (*Assignments, Mergers, Acquisitions*), whether Contractor is the merging party or the acquiring party, DHCS, in its sole discretion, retains the right to terminate this Contract.

a) DHCS will provide written notice of termination to Contractor at least 60 calendar days prior to the effective date of termination.

b) Contractor must fully perform all Contract obligations prior to the effective date of termination. Contractor will not be entitled to additional reimbursement for the services provided following notice of termination until the termination effective date.

c) Termination under this Subsection does not relieve Contractor of its Phaseout Requirement obligations as stated in Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

4) Termination Without Cause

a) DHCS may terminate this Contract and award a new contract for one or more of the Service Areas to another Medi-Cal managed care plan during one of the amendment periods as described in Exhibit E, Subsection 1.1.15 (*Contract Extension*).

b) Notwithstanding any other provision in this Contract, DHCS may terminate this Contract in whole or in part at any time at DHCS' sole discretion.

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c) DHCS will notify Contractor of termination under this Exhibit E, Subsection 1.1.16 (*Termination*) at least six months prior to the effective date of termination to allow for all Phaseout Requirements to be completed.

B. Contractor-Initiated Terminations

Contractor may only terminate this Contract under one or more of the following circumstances:

1) For Rating Periods subsequent to Calendar Year 2024, if Contractor does not accept the Capitation Payment rates determined by DHCS, or if DHCS decides to negotiate the Capitation Payment rates and the parties do not agree on the rates; or

2) When a change in contractual obligations is created by a State or federal change in the Medi-Cal program or a lawsuit that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the term of the Contract, the following will apply:

a) Contractor will submit a detailed written financial analysis to DHCS supporting its conclusions that it cannot remain financially solvent. At DHCS' request, Contractor will submit or otherwise make available to DHCS all of Contractor's financial work papers, financial reports, financial books and other records, bank statements, computer records, and any other information requested by DHCS to evaluate Contractor's financial analysis;

b) DHCS and Contractor may negotiate an earlier termination date than the termination date set forth in this Subsection 1.16.B, if Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this Subsection;

c) Contractor must provide at least a six-month written notice of termination under this Exhibit E, Subsection 1.1.16 (*Termination*). The effective date of termination will be December 31 of the year in which Contractor gives notice,

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unless the date of notice is less than six months before December 31. In that event, termination under this Exhibit E, Subsection 1.1.16 (*Termination*) will be effective no earlier than December 31 of the following year.

d) Termination under these circumstances does not relieve Contractor of its obligations as stated in Exhibit E, Subsection 1.1.17 (*Phaseout Requirements).*

C. Termination of Obligations

Contractor's obligations to provide Covered Services under this Contract or under any Contract extension terminate on the date the Operations Period ends.

D. Notice to Members of Transfer of Care

Following notice of termination by either DHCS or Contractor, notice to the Member will be directed by DHCS. Contractor will not send any notices to its Members regarding the termination unless it receives prior approval from DHCS.

1.1.17 Phaseout Requirements

A. DHCS will retain Capitation Payment for each Service Area from Contractor's Capitation Payment for the last four months of the Operations Period for each Service Area, or Contractor must provide a performance bond to DHCS of an equal amount, until all Directive Payment Initiatives and Supplemental Payments have been calculated and processed by DHCS and all activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

Upon DHCS' processing of all Directive Payment Initiatives and Supplemental Payments and the completion of all Phaseout Period activities for each Service Area, the withhold will be paid to Contractor or the performance bond will be released. If Contractor fails to meet any requirements of the Phaseout Period for each Service Area, DHCS will deduct the costs of the remaining activities from the withhold amount and continue to withhold payment until all activities are completed.

B. The objective of the Phaseout Period is to ensure that, in connection with the expiration or termination of this Contract, Contractor ensures an orderly transfer of necessary data and history records to DHCS or to a

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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

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A. As a condition of entering into this Contract, Contractor agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents, and employees from any and all claims and losses accruing or resulting from any and all Network Providers, Subcontractors, Downstream Subcontractors, suppliers, laborers, and any other person, firm, or corporation furnishing or supplying work services, materials, or supplies in connection with the performance of this Contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by Contractor in the performance of this Contract.

B. Contractor further agrees to indemnify, defend, and hold harmless the State, DHCS and its officers, agents, and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, and any Administrative Costs incurred by DHCS or a Member from any and all litigation, arbitration or mediation resulting directly, indirectly, or arising out of Contractor's denial, delay, or modification of requested Covered Services.

C. Contractor further agrees to indemnify, defend, and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, including DHCS' defense costs, judgments, damages, any Administrative Costs incurred from claims that Contractor violated the Telephone Consumer Protection Act of 1991, 47 USC section 227 *et seq*., and/or related Federal Communications Commission regulations in the performance of this Contract.

D. Contractor further agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any Administrative Costs incurred to the extent DHCS is required to provide notice to affected Members and Potential Members, and any other costs associated with any actual or alleged breach, by Contractor and any vendor, Subcontractor, Downstream Subcontractor, or Network Provider Contractor contracts with in the performance of this Contract, of the following statutes and regulations: the of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), 42 USC section 17921 *et seq.*, and their implementing privacy and security regulations at 45 CFR parts 160 and 164 and the Information Practices Act, and Civil Code (CC) section 1798 *et seq.* by Contractor.

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E. DHCS is authorized to withhold any and all attorneys' fees and costs, judgments, damages, any Administrative Costs incurred pursuant to this indemnification agreement, from Contractor's next Capitation Payment or any other method to recoup DHCS' costs from Contractor.

1.1.19 Sanctions

A. Contractor is subject to sanctions and civil penalties for the specific conduct set forth in 42 CFR sections 438.700, 438.702, 438.704, 438.706, and 438.708. DHCS is also authorized to impose additional sanctions on Contractor pursuant to 42 CFR section 438.702(b) as set forth in W&I section 14197.7, APL 23-012, and any other applicable law.

B. Monetary sanctions imposed pursuant to W&I section 14197.7 may be separately and independently assessed and may also be assessed for each day Contractor fails to correct an identified deficiency. For deficiencies that impact Members and Potential Members, each impacted Member or Potential Member constitutes a separate violation for the purposes of imposing a monetary sanction.

C. Good cause for imposing monetary sanctions includes but is not limited to a breach of this Contract, a violation of a legal obligation (including, but not limited to, obligations imposed by statute, regulation, APL, PL, or other DHCS Guidance), a finding of deficiency that results in an improper denial or delay in the delivery of health care services, potential endangerment of a Member's care, disruption in Contractor's Network, failure to approve continuity of care for a Member, failure to timely and correctly reimburse claims, or a delay in required reporting to DHCS. Further grounds for imposing sanctions include, but are not limited to, those set forth in 42 CFR section 438.700 et seq., W&I section 14197.7, and APL 23-012.

D. DHCS may identify findings of noncompliance or good cause through any means, including, but not limited to, findings in audits; investigations; contract compliance reviews; Quality Improvement System monitoring; routine monitoring; facility site surveys; Encounter Data submissions; Grievances and Appeals; Network adequacy reviews; assessments of timely access requirements; reviews of utilization data; health plan rating systems; State Hearing decisions; IMR decisions; complaints from Members, Providers, Network Providers, Subcontractors, Downstream Subcontractors, other stakeholders, or whistleblowers; and Contractor's self-disclosures.

E. Sanctions in the form of denial of payments provided for under this Contract for new Members will be taken, when and for as long as,

payment for those Members is denied by CMS under 42 CFR section 438.730.

F. DHCS may also impose nonmonetary sanctions as set forth in 42 CFR section 438.700 et seq., W&I section 14197.7, APL 23-012, and any other applicable law.

G. DHCS is not required to impose a Corrective Action plan on Contractor before imposing any of the sanctions set forth in this Section or in State and federal law.

H. DHCS may impose sanctions in addition to any monetary damages recovered pursuant to Exhibit E, Subsection 1.1.20 (*Liquidated Damages*).

1.1.20 Liquidated Damages

A. If Contractor breaches this Contract, DHCS will be entitled to all legal and equitable remedies available under the law, including monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages.

B. Contractor agrees that any breach of this Contract, including but not limited to a breach due to Contractor's delay in implementing new program requirements or plan readiness requirements or Contractor's failure to meet its Quality or Network Adequacy obligations, may result in damage to the State or DHCS that is difficult to quantify. In the event of such a breach, Contractor agrees that the Director is authorized to impose liquidated damages on Contractor in the amount of $25,000 for each separate and distinct breach in addition to liquidated damages in the amount of $25,000 for each day Contractor fails to remedy the breach, which the Parties agree bears a reasonable relationship to the range of actual damages the Parties anticipate would flow from such a breach.

C. Contractor acknowledges that DHCS' authority to impose monetary sanctions and other intermediate sanctions pursuant to 42 CFR section 438.700 *et seq*. and W&I section 14197.7, as set forth in Exhibit E, Subsection 1.1.19 (*Sanctions*), is separate and distinct, and that DHCS may recover damages for Contractor's breach, including liquidated damages, in addition to any sanctions imposed under Exhibit E, Subsection 1.1.19 *(Sanctions).*

1.1.21 Contractor's Dispute Resolution Requirements

Contractor must comply with and exhaust the requirements of this Section when it initiates a contract dispute with DHCS. This Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*) does not apply to challenges to sanctions as described in Exhibit E, Subsection 1.1.19 *(Sanctions)* liquidated damages as described in Exhibit E, Subsection 1.1.20 *(Liquidated Damages)*, or any other contract compliance action initiated by DHCS. Contractor's filing of a Notice of Dispute, as defined in Paragraph B of this Section, does not preclude DHCS from withholding or recouping the value of the amount in dispute from Contractor, or from offsetting the amount in dispute from subsequent Capitation Payment(s).

A. Resolution of Dispute by Negotiation

Contractor agrees to make best efforts to resolve all alleged contractual issues by negotiation and mutual agreement at the DHCS Contracting Officer level before appealing to the DHCS Office of Administrative Hearings and Appeals (OAHA). Contractor must exhaust OAHA's appeal process before filing a writ in Sacramento County Superior Court. During the negotiations to resolve Contractor's issues, DHCS and Contractor may agree, in writing, to an extension of time for continuing negotiations to resolve Contractor's dispute before the decision of the DHCS Contracting Officer is issued.

B. Notice of Dispute

Within 30 calendar days from the date that the alleged dispute arises or otherwise becomes known to Contractor, Contractor must serve a written notice of dispute to the DHCS Contract Manager. Contractor's failure to serve its notice of dispute within 30 calendar days from the date the alleged dispute arises or otherwise becomes known to Contractor constitutes a waiver of all issues raised in Contractor's notice of dispute.

Contractor's notice of dispute must include, based on the most accurate information and substantiating documentation available to Contractor, the following:

1) That the dispute is subject to the procedures in this Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*);

2) The date, nature, and circumstances of the alleged conduct that is subject of the dispute;

3) The names, phone numbers, functions, and conduct of every Subcontractor, Downstream Subcontractor, Network Provider,

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DHCS/State official or employee involved in or knowledgeable of the alleged issue(s) that is the subject of the dispute;

4) The identification of any substantiating documents and the substance of any oral communications that are relevant to the alleged conduct;
5) Copies of all substantiating documentation and any other evidence attached to its notice of dispute;

6) The factual and legal bases supporting Contractor's notice of dispute;

7) The cost impact to Contractor directly attributable to the alleged conduct, if any; and

8) Contractor's desired remedy.

After Contractor submits its notice of dispute with all accurate available substantiating documentation, Contractor must comply with 22 CCR section 53851(d) and diligently continue performance of its obligations under this Contract, including compliance with contract requirements that are the subject of, or related to, Contractor's notice of dispute.

If Contractor requests and DHCS agrees, Contractor's notice of dispute may be decided by an alternate dispute officer (ADO). DHCS will designate an ADO who was not directly involved in the alleged conduct that prompted Contractor's notice of dispute.

Any appeal of the DHCS Contracting Officer's decision to OAHA or a writ seeking review of OAHA's decision in Sacramento County Superior Court is limited to the issues and arguments set forth and properly documented in Contractor's notice of dispute, that were not waived or resolved.

C. Timeframes

The DHCS Contracting Officer or ADO will have 90 calendar days to review Contractor's initial notice of dispute and available substantiating documentation and issue a decision unless there is a written agreement between DHCS and Contractor to extend that time. If the DHCS Contracting Officer or ADO determines that additional substantiating documentation is required, they will provide Contractor with a written request identifying the issue(s) requiring additional supporting documentation. Contractor must provide that additional substantiating documentation no later than 30 calendar days from receipt of the request.

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Unless Contractor and the DHCS Contracting Officer or ADO agree to an extension of time, in writing, Contractor's failure to provide additional substantiating documentation, or otherwise notify the DHCS Contracting Officer or ADO that no additional documents exist, within 30 calendar days from the request, constitutes Contractor's waiver of all issues raised in Contractor's notice of dispute.

Issues raised by Contractor in the notice of dispute will be decided by the DHCS Contracting Officer or the ADO within 90 calendar days from receipt of Contractor's substantiating documentation or within 60 calendar days from receipt of all additionally requested substantiating documentation from Contractor, whichever is later.

D. The DHCS Contracting Officer's or ADO's Decision

1) If the DHCS Contracting Officer or the ADO finds in favor of Contractor, they may:

a) Correct the conduct which prompted Contractor's notice of dispute; or

b) Require performance of the disputed conduct and, if there is a cost impact sufficient to constitute a material change in obligations pursuant to the payment provisions under Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*), direct DHCS to comply with that Exhibit. In the event of such a finding DHCS will not owe interest on any underpayment found due and owing pursuant to the notice of dispute.

2)~~3)~~ If DHCS' Contracting Officer or the ADO denies Contractor's notice of dispute, they are authorized to direct the manner of Contractor's future contractual performance.

E. Appeal of the DHCS Contracting Officer's or ADO's Decision

1) Contractor will have 30 calendar days following the receipt of DHCS Contracting Officer's or ADO's decision to appeal the decision to the Director, through OAHA. All of Contractor's appeals will be governed by H&S section 100171, except Government Code (GC) section 11511 relating to depositions will not apply. The venue of OAHA appeals will be in Sacramento.

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2) All of Contractor's appeals must be in writing and must be filed with OAHA and a copy sent to the Chief Counsel of DHCS and DHCS Contract Manager. Contractor's appeal will be deemed filed on the date it is received by OAHA. Contractor's appeal must specifically set forth the unresolved issues that remain in dispute and issues that have not been waived because of Contractor's failure to provide all substantiating documentation to DHCS, as specified in Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*). Additionally, Contractor's appeal is solely limited to the issues raised in its notice of dispute that have not been resolved or waived.

3) Contractor has the burden of proof of demonstrating that its position is correct and must show by a preponderance of evidence that:

   a) DHCS acted improperly such that it breached this Contract; and

   b) Contractor sustained a cost impact directly related to DHCS' breach.

4) OAHA's jurisdiction is limited to issues and arguments raised in the notice of dispute that were not waived either by the untimely filing of the notice of dispute or statement of disputed issues, or by Contractor's failure to provide all requested substantiating documentation requested by DHCS Contracting Officer or ADO or otherwise resolved by Contractor and DHCS.

5) Contractor's failure to timely appeal the decision to OAHA constitutes a waiver by Contractor of all issues raised in Contractor's notice of dispute. This waiver of claims also precludes the filing of a writ in Sacramento Superior Court, or any other court.

F. No Obligation to Pay Interest

If Contractor prevails on its notice of dispute pursuant to a DHCS Contracting Officer's or ADO's decision, an OAHA decision, or an order or decision issued by ~~the Sacramento County Superior Court~~ **any State or federal court, including** ~~or~~ any ~~California~~ **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

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Contractor must comply with all requirements of 22 CCR section 53851(d) and all obligations under this Contract, including continuing Contract requirements that are the subject of, or related to, Contractor's notice of dispute until there is a final decision from the DHCS Contracting Officer, the ADO or a decision on an appeal in Sacramento County Superior Court.

H. Waiver of Claims

Contractor waives all claims or issues if it fails to timely submit a notice of dispute with all substantiating documents within the timeframes noted in Subsection 1.1.21.C, above. Contractor also waives all claims or issues set forth in its notice of dispute if it fails to timely submit all additional substantiating documentation within 30 calendar days of the DHCS Contracting Officer's or ADO's request, or if it fails to timely appeal the DHCS Contracting Officer's or ADO's decision in the manner and within the time specified in this Subsection 1.1.21. Contractor's waiver includes all damages whether direct or consequential in nature.

1.1.22 Inspection and Audit of Records and Facilities

A. Recordkeeping Requirements

1) Records to be Maintained

Contractor must maintain all records and documents necessary to disclose how Contractor discharges its obligations under this Contract. These records and documents will disclose the quantity of Covered Services provided under this Contract, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the manner in which Contractor administered its daily business, and the cost thereof.

Contractor must maintain all working papers, reports submitted to (DHCS, DMHC, Division of Medi-Cal Fraud & Elder Abuse (DMFEA), United States Department of Health & Human Services (U.S. DHHS), and United States Department of Justice (US DOJ), financial records, books of account, Medical Records, prescription files, laboratory results, Subcontractor Agreements, Downstream Subcontractor Agreements, and Network Provider Agreements, information systems and procedures, and any other documentation

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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.

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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:

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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.

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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

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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.

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2) Contractor must ensure that Providers do not refuse to provide Covered Services to Members, when OHC is indicated on a Member's Medi-Cal eligibility record.

3) Contractor must allow Providers to direct bill services that meet DHCS' requirements for direct billing without attempting to Cost Avoid those services. Cost Avoidance is not required prior to payment for services provided to Members with OHC codes A or N. More information on services that qualify for direct billing can be found in the Medi-Cal Provider Manual, Part 2 – General Medicine, section "Other Health Coverage (OHC): CPT-4 and HCPCS Codes (oth hlth cpt)".

4) Prior to delivering services, Contractor must ensure that Providers review the Member's Medi-Cal eligibility record for third-party coverage, designated by OHC or Medicare coverage code. If the Member's Medi-Cal eligibility record indicates OHC and the requested service is covered by OHC, Contractor must ensure that Providers notify the Member to seek the service from OHC.

5) When Contractor denies a claim due to OHC, Contractor must include OHC information in its notice of claim denial to Provider. OHC information includes, but is not limited to, the name of the OHC or Medicare carrier, and contact or billing information of the OHC.

H. Reporting Requirements for Cost Avoidance

Contractor must report new OHC information not found on the Medi-Cal eligibility record or that is different from what is reflected on the Medi-Cal eligibility record to DHCS within ten calendar days of discovery. Contractor must report discrepancies in the Medi-Cal record by either completing and submitting an OHC removal or addition form found online at https://www.dhcs.ca.gov or reporting OHC information to DHCS in batch updates. Batch updates regarding OHC information are processed by DHCS on a weekly basis. Contractor may contact its DHCS Contract Manager for more information regarding this process.

I. Post-Payment Recovery

1) Contractor must pay Provider's claim and then seek to recover the cost of the claim by billing the liable third parties in either of the following circumstances:

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a) The Member had OHC code A on their Medi-Cal eligibility record at the time of service; or

b) For services defined by DHCS as preventive pediatric services.

2) When Contractor discovers that a service was provided to a Member with OHC designated in the Medi-Cal eligibility record, and Contractor did not properly Cost Avoid the service, then Contractor must bill the OHC for the cost of actual services rendered. If OHC is discovered retroactively, Contractor must also bill the OHC for the cost of actual services rendered.

3) Contractor must bill the liable OHC for the cost of services provided to Members. Billing and recoupment must be completed within 12 months from the date of payment of a service.

4) Monies recovered by DHCS or DHCS' contracted recovery agent starting on the first day of the 13th month after the date of payment of a service will be retained by DHCS.

J. Reporting Requirements

Contractor must submit a monthly PPR Report to DHCS via Secure File Transfer Protocol (SFTP) by the 15th day of each month in a format specified by DHCS in APLs. This report must contain claims and recovery information and any other information specified by DHCS in APLs.

K. Contractor must have written policies and procedures implementing all of the requirements of this Subsection 1.1.25 (*Cost Avoidance and Post-Payment Recovery of Other Health Coverage*).

1.1.26 Third-Party Tort and Workers' Compensation Liability

Contractor must not make a claim for recovery of the value of Covered Services rendered to a Member in cases or instances involving casualty insurance, tort, Workers' Compensation, or class action claims. Contractor's failure to comply with this provision is non-delegable. In the event that Contractor's failure to comply with this provision negatively impacts DHCS' ability to recover its full statutory lien, DHCS reserves the right to deduct any losses from Contractor's Capitation Payments. To assist DHCS in exercising DHCS' exclusive responsibility for recovering casualty insurance, tort, Workers' Compensation, or class action claims, Contractor must meet the following requirements:

A. Within 30 calendar days of DHCS' request, submit all requested service and utilization information and, when requested, copies of paid invoices/claims for its Members, including information from Network Providers, out-of-Network Providers, Subcontractors, and Downstream Subcontractors. Service and utilization information and copies of paid invoices/claims must set out any services provided by Contractor, including, but not limited to, physical, mental, and dental health services. Records must include services provided on a Fee-For-Service, capitated basis, and any other payment arrangements, regardless of whether a payment was made or denied. The reasonable value of the services must be calculated as the usual, customary, and reasonable charge made to the general public for similar services, or the amount paid to Network Providers or out-of-Network Providers for similar services. No additional payment will be made to Contractor for compliance with this provision.

B. Submit the requested service and utilization information and paid invoices/claims in a form and manner specified by DHCS through DHCS designated SFTP, in compliance with the electronic format and process, as set forth in APLs . Contractor must include the attestation in a form and manner specified by DHCS signed by the custodian of records or a designee with knowledge of the Member Information provided to DHCS, as set forth in APLs.

C. Notify DHCS using the appropriate online notification form at the Third Party Liability and Recovery Division Online Forms page, https://dhcs.ca.gov/PIForms, within ten calendar days of receiving a request from attorneys, insurers, or Members for a lien, pursuant to DHCS' recovery rights. These requirements do not relieve Contractor of other legal duties to Contractor's Members or other entities, including, without limitation, the duty to respond to Members' requests for their own Protected Health Information pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

D. Use the TPLManagedCare@dhcs.ca.gov inbox for all communications regarding Contractor's service and utilization information and copies of paid invoices/claims file submissions, to submit questions or comments related to the preparation and submission of these reports, and for issues related to accessing the SFTP folders.

E. Have written policies and procedures implementing all of the requirements of this Exhibit E, Subsection 1.1.26 (*Third-Party Tort and Workers' Compensation Liability*).

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1.1.27 Litigation Support

A. Records

Upon request by DHCS, Contractor must timely gather, preserve, and provide, in the form and manner specified by DHCS, any information, subject to any lawful privileges, in the possession of Contractor or its Subcontractors, Downstream Subcontractors, or Network Providers , relating to threatened or pending litigation by or against DHCS. If Contractor asserts that any requested documents are covered by a lawful privilege, Contractor must:

1) Sufficiently identify the claimed privileged documents to reasonably identify the documents; and

2). State the privilege being claimed that supports withholding production of the document.

Contractor agrees to promptly provide DHCS with a copy of any documents provided to any party in any litigation by or against DHCS. Contractor acknowledges that time is of the essence in responding to such a request. Contractor will use its best efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records received by Contractor or its Subcontractors, Downstream Subcontractors, or Network Providers related to this Contract or the Subcontractor Agreements, Downstream Subcontractor Agreements, and Network Provider Agreements entered into under this Contract.

B. Document Authentication and Testimony

Contractor will make its personnel and employees available to DHCS to authenticate documents, provide testimony as a witness, act as a “person most knowledgeable,” and assist in other ways as requested by DHCS, in connection with litigation, Public Record Acts requests, subpoenas, inquiries, and/or audits by federal and State agencies and departments, and inquiries by third-parties, as requested by DHCS. No additional payments will be paid to Contractor for the activities described in this Exhibit E, Subsection 1.1.27 (*Litigation Support*).

1.1.28 Equal Opportunity Employer

Contractor must comply with all applicable federal and State employment discrimination laws. Contractor, must:

A. In all solicitations or advertisements for employees placed by or on behalf of Contractor, state that it is an equal opportunity employer;

B. Send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a DHCS-approved notice, advising the labor union or workers' representative of its commitment as an equal opportunity employer and post copies of the notice in conspicuous places available to employees and applicants for employment;

C. Not unlawfully discriminate against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military and veteran status;

D. Ensure that the evaluation and treatment of its employees and applicants for employment are free of such discrimination and comply with the provisions of the Fair Employment and Housing Act (GC §12900 *et seq*.), and the applicable regulations promulgated thereunder (2 CCR § 11000 *et seq.*). The applicable regulations of the Fair Employment and Housing Council implementing GC section 12990, set forth in Subchapter 5 of Division 4.1 of Title 2 of the California Code of Regulations are incorporated into this Contract by reference and made a part hereof as if set forth in full;

E. Give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement; and

F. Include the nondiscrimination and compliance provisions of this clause in all contracts to perform work under the Contract, in accordance with 2 CCR section 11105.

1.1.29 Federal and State Nondiscrimination Requirements

Contractor must:

A. Comply with federal nondiscrimination requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973, as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing

regulations promulgated under the above-listed statutes; and

B. Comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, GC sections 7405 and 11135, W&I section 14029.91, and State implementing regulations.

1.1.30 Discrimination Prohibitions

A. Member Discrimination Prohibition

Contractor must not unlawfully discriminate against Members or Potential Members on the basis of any characteristic protected under federal or State nondiscrimination law, including sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, in accordance with the statutes identified in Exhibit E, Subsection 1.1.29 (*Federal and State Nondiscrimination Requirements*) above, rules and regulations promulgated pursuant thereto, or as otherwise provided by law. For the purpose of this Contract, discrimination includes, but is not limited to, unlawfully:

1) Denying any Member Covered Services or availability of a Facility;

2) Providing a Member with any Covered Service that is different, or is provided in a different manner or at a different time from that which is provided to other Members under this Contract except where medically indicated;

3) Subjecting a Member to segregation, separate treatment, or harassment in any manner related to the receipt of any Covered Service;

4) Restricting or harassing a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; treating a Member or Potential Member differently from others in determining whether they satisfy any admission, Enrollment, quota, eligibility, membership; or adding other requirements or conditions which Members must meet in order to be provided any Covered Service;

5) Assigning times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, to the Members to be served;

6) Utilizing criteria or methods of administration which have the effect of subjecting individuals to discrimination;

7) Failing to make Auxiliary Aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and

8) Failing to ensure meaningful access to programs and activities for Limited English Proficient (LEP) Members and Potential Members.

B. Member Affirmative Action

Contractor must take affirmative action to ensure that Members are provided Covered Services without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, except as needed to provide equal access to LEP Members or Members with disabilities, or where medically indicated. For the purposes of this Section, genetic information includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

C. Discrimination Related To Health Status

Contractor must not discriminate against Members or Potential Members on the basis of their health status or requirements for health care services during Enrollment, re-Enrollment or disenrollment. Contractor must not terminate the Enrollment of a Member based on an adverse change in the Member’s health.

1.1.31 Small Business Participation and Disabled Veteran Business Enterprises Reporting Requirements

A. Contractor must comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at Public Contract (PC) Code section 10230.

B. If for this Contract, Contractor made a commitment to achieve small business participation, then Contractor must annually and within 60 calendar days of receiving final payment under this Contract report to DHCS the actual percentage of small business participation that was achieved (GC § 14841).

C. If for this Contract, Contractor made a commitment to achieve DVBE participation, then Contractor must annually and within 60 calendar days of receiving final payment under this Contract certify in a report to DHCS:

1) The total amount Contractor received under the Contract;

2) The name and address of the DVBE(s) that participated in the performance of the Contract;

3) The amount each DVBE received from Contractor;

4) That all payments under the Contract have been made to the DVBE; and

5) The actual percentage of DVBE participation that was achieved. (Military and Veterans Code § 999.5(d); GC § 14841

1.1.32 Conflict of Interest Avoidance Requirements

Contractor will comply with all requirements relating to Contractor's obligations to avoid conflicts of interest as described in Exhibit H (*Conflict of Interest Avoidance Requirements*).

1.1.33 Guaranty Provision

If Contractor is a subsidiary of another entity, Contractor must submit a guaranty from any entity in Contractor's chain of ownership that is publicly traded. If no such parent entity is publicly traded, the guaranty must be submitted by a parent entity at a level in the chain of ownership that is acceptable to DHCS. The guaranty must meet all requirements set forth in Exhibit I (*Contractor's Parent Guaranty Requirements*) of this Contract and be

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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

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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,

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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.

9.12.5 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.

9.12.6 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

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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

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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;

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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.

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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

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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;

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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)

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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)

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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.

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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)** ~~**Population Health Management Service**~~	☐
4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering	☐
4.3.6 Screening and Assessments	☐
4.3.7 Care Management Programs	☐
4.3.8 Basic Population Health Management	☐
4.3.9 Other Population Health Requirements for Children	☐
4.3.10 Transitional Care Services	☐
4.3.11 Targeted Case Management Services	☐
4.3.12 Mental Health Services	☐
4.3.13 Alcohol and Substance Use Disorder Treatment Services	☐
4.3.14 California Children's Services	☐
4.3.15 Services for Persons with Developmental Disabilities	☐
4.3.16 School-Based Services	☐
4.3.17 Dental	☐
4.3.18 Direct Observed Therapy for Treatment of Tuberculosis	☐
4.3.19 Women, Infants, and Children Supplemental Nutrition Program	☐
4.3.20 Home and Community-Based Services Programs	☐
4.3.21 In-Home Supportive Services	☐
4.3.22 Indian Health Care Providers	☐

Contractual Requirements	Delegated to Subcontractor
4.3.23 Justice Involved Reentry Coordination	☐
4.3.24 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:

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

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

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

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

Specialized Durable Medical Equipment means DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a Physician's description and orders; is made to order or adapted to meet the specific needs of the beneficiary; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

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2.0 **EXHIBIT L** OPERATIONAL READINESS DELIVERABLES AND REQUIREMENTS

	Operational Readiness Requirement
Exhibit L 1	Submit a written transition plan detailing the transfer of case management, Care Coordination, Provider referral, and service authorization administrative functions of the California Children's Services (CCS) program to Contractor to be prepared by the designated county agency and Contractor. The transition plan must include the following: 1) Detailed process for completing all required risk assessments, including telephonic or in-person communications and, for CCS-eligible Members determined to be high risk, all required Individual Care Plans (ICPs) within one year for Whole-Child Model (WCM) transition Members. 2) Process for verifying that approved Subcontractors and Downstream Subcontractors that are delegated risk and are responsible for arranging for the provision of Covered Services are compliant. Refer to All Plan Letter (APL) 21-005 WCM Section: Risk Level and Needs Assessment Process for direction on required deliverable updates. 3) Detailed Dispute Resolutions Policy stating that disagreements between Contractor and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS. Refer to APL 21-005 WCM Section: Dispute Resolution and Provider Grievances for direction on required deliverable update.
Exhibit L 2	Submit the executed WCM Memorandum of Understanding (MOU) or evidence indicating a reasonable effort to finalize the MOU with the county CCS program. Additionally, the MOU must address Contractor and CCS coordination with regards to Medical Therapy Unit services.
Exhibit L 3	Submit a Provider network that includes an appropriate number of CCS Providers adequate to serve the needs of CCS-eligible Members in the Service Area.
Exhibit L 4	Submit an updated Provider network via the Provider Network Readiness template. Contractor must complete and submit the provided template and include additional contracted CCS-paneled Providers, allied and medical supportive personnel, Durable Medical Equipment (DME) Providers, and approved Provider facilities, including: Specialists, Tertiary and Pediatric

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	Community Hospitals, Neonatal Intensive Care Units, and Special Care Centers.
Exhibit L 5	Submit policies and procedures to ensure continuity of care for CCS-eligible Members with their CCS Providers, Specialized Durable Medical Equipment Providers, and Prescription Drugs.
Exhibit L 6	Submit updated policies and procedures that outline Continuity of Care (COC) for CCS-Medically Necessary services, including the following: 1) COC for CCS-eligible Members to receive services outside of Contractor's Subcontractor if there is a WCM network certification deficiency within Contractor's Subcontractor Network. 2) COC is allowed for CCS-eligible Members to continue to receive services from their previous DE, including their assigned PCP, for those who are required to select or be reassigned to a new DE. Contractor and its Subcontractors and Downstream Subcontractors must comply with COC requirements outlined in APL 22-032 and APL 21-005.
Exhibit L 7	Submit Provider network analysis to demonstrate the availability of an appropriate Provider network to serve the needs of CCS Members, including Primary Care Providers (PCP), pediatric Specialists and sub-Specialists, professional, allied, and medical supportive personnel, licensed acute care hospitals, special care centers, and DME Providers.
Exhibit L 8	Submit Contractor's standard, monthly 274 file(s) to the PACES production environment to confirm that the proposed Provider network supplied through the Provider Network Readiness template was realized via executed contracts, and the Provider network meets the needs of CCS Members.
Exhibit L 9	Submit an attestation that Contractor and its Subcontractors and Downstream Subcontractors will work to execute contracts with all Providers included on the updated Provider Network Readiness template submission.
Exhibit L 10	Submit updated policies and procedures for ensuring Subcontractors and Downstream Subcontractors fully comply with all the terms and conditions of this Contract with WCM network certification requirements including: 1) Policies and procedures for ensuring Subcontractors and Downstream Subcontractors meet WCM operational requirements included in the contract as well as APL 21-005. 2) Process for ensuring a Subcontractor and Downstream Subcontractor meets WCM network certification requirements.

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	3) Oversight and readiness activities for Subcontractors and Downstream Subcontractors for Phase 2 to demonstrate requirements are met for implementation including: a) Subcontractor and Downstream Subcontractor Correspondence/Bulletins b) Agendas and Meeting Notes regarding WCM c) Policies and Procedures of review process for Subcontractors and Downstream Subcontractors 4) Oversight and enhanced readiness activities for Subcontractors and Downstream Subcontractors for Phase 3 to demonstrate requirements are met for implementation including: a) Subcontractor and Downstream Subcontractor Correspondence/Bulletins b) Agendas and Meeting Notes regarding WCM c) Policies and Procedures review process for Subcontractors and Downstream Subcontractors.
Exhibit L 11	Submit updated policies and procedures to ensure that credentialing and re-credentialing includes and speaks to CCS Providers.
Exhibit L 12	Submit attestation that no CCS-eligible Members will be enrolled or assigned to a Subcontractor and Downstream Subcontractor that is excluded from participating in WCM and that Contractor will allow Members access to CCS-paneled providers within all of Contractor's Provider network for CCS services. Provide process for how Contractor will ensure that that no CCS-eligible Members will be enrolled or assigned to a DE that is excluded from participating in WCM.
Exhibit L 13	Submit updated policies and procedures to include details surrounding the processes by which a CCS-eligible Member may maintain access to a Provider or a Specialized DME Provider for up to 12 months. The policy and procedure must endure the following: 1) COC requirements for pharmaceutical services and the provision of prescribed drugs, as described in contract Exhibit A, Attachment III, Subsection 5.3.7.H (*Services for All Members*), are applied to CCS-eligible Members. 2) Contractor must send a written notice to the Member 60 days before the 12-month authorization expires. 3) Allow a CCS-eligible Member, or a family member or caregiver of a CCS beneficiary, to appeal the continuity of care 12-month limitation to the Director or their designee.

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Exhibit L 14	Submit updated policies and procedures to explain the approach and development of ICPs for CCS-eligible Members based on the results of the pediatric health risk assessment process. ICPs must be completed with a particular focus on CCS specialty care, consider behavioral health needs, and must coordinate those services. If needed, Contractor must facilitate a CCS-eligible Member's ability to access appropriate community resources and other agencies, including referrals for behavioral services such as Specialty Mental Health Services and Substance Use Disorder services. The policies and procedures must include access for families to know where to go for ongoing information, education, and support so that they understand the goals, treatment plan, and course of care for their Child and their role in the process, what it means to have primary or specialty care for their Child, when it is time to call a PCP, Specialist, urgent care, or emergency room, what an interdisciplinary care team is, and what the community resources are. Risk Level and Needs Assessment. Refer to APL 21-005 WCM Section: Risk Level and Needs Assessment Process, for direction on required deliverable updates.

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3.0 Whole Child Model Program

3.1 Whole Child Model Scope of Services
3.2 Required Reports for the Whole Child Model Program
3.3 Data Sharing Links
3.4 Whole Child Model Payments

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3.1 Whole Child Model Scope of Services

3.1.1 Whole Child Model Program Compliance

Contractor agrees to implement the Whole Child Model (WCM) program, as directed by DHCS and in accordance with Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) and All Plan Letter (APL) 21-005, in order to cover benefits that were previously covered by the California Children's Services (CCS) program. Contractor's implementation of and participation in the WCM program renders this Contract's requirements around CCS, as stated in Exhibit A, Attachment III, Subsection 4.3.14 (*California Children's Services*), and elsewhere in this Contract, inapplicable to Contractor.

A. Contractor must provide all Medically Necessary services previously covered by the CCS program as Covered Services for Members who are eligible for the CCS program at the time of the transition of benefits to Contractor, and for Members who are determined eligible for CCS after the transition of benefits.

B. To ensure consistency in the provision of covered CCS, Contractor must use all current and applicable CCS program guidelines, including CCS program regulations, CCS program information notices, and CCS numbered letters in developing criteria for use by Contractor's Medical Director or the equivalent, and other care management staff. When applicable CCS clinical guidelines do not exist, Contractor must use evidence-based guidelines or treatment protocols that are medically appropriate given the Member's CCS-eligible condition.

   The CCS numbered letters are posted by DHCS at the following web address for guidance on providing CCS Covered Services to Members eligible for CCS:

   http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

C. Contractor must be responsible for all available Medically Necessary Medi-Cal services. Any Medically Necessary CCS services not available as a Medi-Cal Covered Service must remain the responsibility of the State and the county.

D. Contractor must submit its written transition plan to DHCS before commencing the transition to the Whole Child Model. The transition plan will detail how Contractor will transition CCS-eligible Members from the

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county CCS program to the Whole Child Model, and take over responsibility for case management, care coordination, Provider referrals, and service authorizations for Members who are enrolled in the CCS program at the time of the transition, in accordance with Health and Safety Code (H&S) section 123850(b)(1) and APL 21-005.

E. Contractor must provide DHCS with documentation confirming that a local stakeholder process has been established in accordance with Welfare and Institutions Code (W&I) section 14094.7(d)(3). Such documentation may include meeting minutes, a meeting schedule, or other forms of confirmation approved by DHCS.

F. Contractor must execute a MOU with the county CCS program as stipulated in Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*), for the coordination of CCS services to Members. This MOU must include the following:

1) Agreements on the transition of Care Coordination and service authorization for CCS from the county CCS program to Contractor, and how Contractor will work with the county CCS program to ensure continuity and consistency;

2) Policy and procedures for referral to and coordination with the local CCS Medical Therapy Unit (MTU) to ensure appropriate access to MTU services, and other non-MTU services provided under this Contract;

3) A provision to allow a Member eligible for CCS to continue to receive care management and Care Coordination from their current CCS public health nurse, unless this requirement is waived by DHCS in accordance with W&I section 14094.13(h). The Member or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives, must make the request to continue with their current CCS public health nurse within 90 days of their transition to the Whole Child Model, in accordance with W&I section 14094.13(e) and (f).

3.1.2 Annual Medical Eligibility Redeterminations

A. Contractor must provide all necessary documentation, dated within the last six months but no later than 12 months prior to the Member's CCS program eligibility end date to allow for an annual medical eligibility

redetermination by the county CCS program. This includes but is not limited to:

1) The Member's current medical records that document the Member's medical history;

2) Results of physical examinations by a Physician;

3) Laboratory test results;

4) Radiologic findings; and

5) Other tests and examinations that support the diagnosis of the eligible condition(s), including any medical therapy unit diagnosis or high-risk infant follow-up reports.

B. Contractor must provide the documentation to the county CCS program no later than 60 calendar days before the Member's CCS program eligibility end date. If documentation is received after the 60-day timeframe, Contractor and the county CCS program should collaborate to determine the best approach for submitting documents.

C. If the county CCS program requires additional documentation, Contractor must, upon notification from the county CCS program, coordinate with the Member's Provider(s) to obtain any needed documentation, within the agreed upon timeframe, to support the county CCS program's medical redetermination efforts.

D. Contractor must proactively engage in a collaborative process with the county CCS program to remedy any issues or challenges related to timeliness or completeness of records for the medical eligibility redetermination process.

E. For disputes between Contractor and the county CCS program regarding CCS medical eligibility determinations where a resolution cannot be reached, Contractor may refer the dispute directly to DHCS for review and a final determination.

3.1.3 CCS Advisory Committees

A. Contractor must create and maintain a CCS clinical advisory committee, separate and distinct from its Quality Improvement and Health Equity

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Committee described in Exhibit A, Attachment III, Section 2.3 (*Quality Improvement and Health Equity Committee*). The CCS clinical advisory committee must be composed of Contractor's Medical Director or the equivalent, the county CCS medical director, and at least four CCS-paneled Providers.

1) The CCS clinical advisory committee must advise on clinical issues relating to CCS conditions, including treatment authorization guidelines, and to serve as clinical advisers on other clinical issues relating to CCS conditions.

2) The CCS clinical advisory committee must meet at least quarterly, or more frequently if determined necessary.

B. Contractor must establish a CCS family advisory group that is separate and distinct from its Community Advisory Committee described in Exhibit A, Attachment III, Subsection 5.2.11.E (*Cultural and Linguistic Programs and Committees*), and is specifically for CCS families.

1) The CCS family advisory group must be comprised of CCS-eligible Members' parents, custodial parents, legal guardians, or other Authorized Representatives. Family representatives who serve may receive a reasonable per diem payment to enable in-person participation in the CCS family advisory group.

2) Contractor may conduct CCS family advisory group meetings at least quarterly and utilize teleconference or other similar electronic means to facilitate participation.

3) A representative of the CCS family advisory group must be invited to serve on the DHCS statewide stakeholder advisory group for CCS.

3.1.4 CCS Provider Network

A. Contractor must include in their Network an adequate number of CCS Providers able to serve the needs of Members with CCS conditions and receive timely access. Contractor must utilize only paneled CCS Providers to treat CCS conditions when a CCS-eligible Member's condition requires treatment from the Provider types described in this Provision. DHCS remains responsible for paneling CCS Providers. Contractor may use an out-of-state Provider, in accordance with APL 19-004, if an in-state CCS

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Provider does not possess the clinical expertise to appropriately treat the Member's CCS condition.

B. In addition to the Network requirements found in Exhibit A, Attachment III, Subsection 5.2.3 (*Network Composition*), Contractor must also include the following:

1) An adequate number of hospitals and/or facilities that include neonatal intensive care units, CCS-approved pediatric intensive care units, and CCS-approved inpatient facilities.

2) Licensed acute care hospitals and special care centers approved by the CCS program to treat a CCS-eligible condition.

3) That among the pediatric Network Providers are an adequate number of CCS-paneled Providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty.

C. In addition to the requirements in Exhibit A, Attachment III, Subsection 2.2.13 (*Credentialing and Recredentialing*), Contractor must credential CCS Providers in accordance with APL 21-005.

D. CCS Providers must be able to utilize Contractor's Provider Dispute Resolution Mechanism, as described in Exhibit A, Attachment III, Section 3.2.2 (*Provider Dispute Resolution Mechanism*).

3.1.5 Provider Compensation

In addition to the requirements found in Exhibit A, Attachment III, Section 3.3 (*Provider Compensation Arrangements*), Contractor must also reimburse Physicians and surgeons providing CCS to eligible Members at rates that are equal to or exceed the applicable CCS Fee-For-Service (FFS) rates, unless the Physician and surgeon enters into an agreement on an alternative payment methodology mutually agreed to by the Physician and surgeon and Contractor.

3.1.6 Covered Services

In addition to the requirements found in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*), Contractor must cover CCS for Members determined to be eligible in accordance with the CCS program medical eligibility regulations. Upon diagnostic evidence that a Member under 21 years of age may have a CCS-

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eligible condition, Contractor must refer the Member to the county CCS office for eligibility determination.

A. Contractor must ensure assessment and Care Coordination for the transition of Members who are eligible for CCS and receiving services through the CCS program at the time of the transition, as required below in Exhibit L, Subsection 3.1.9 (*Care Management and Coordination of Care*).

B. For the identification of a Member eligible for CCS, Contractor must ensure the following:

1) Network Providers must perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that a Member has a CCS-eligible medical condition.

2) Initial referrals of Member's with CCS-eligible conditions must be made to the county CCS program by telephone, same day mail, or fax or other secure electronic system, if available. The initial referral must be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the county CCS program.

3) Contractor must provide all Medically Necessary CCS Covered Services for the Member's CCS-eligible condition(s).

4) If the county CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary Covered Services to the Member, including Early Periodic Screening, Diagnosis and Testing (EPSDT) as required in Exhibit A, Attachment III, Subsection 5.3.4.F (*Services for Members Less Than 21 Years of Age*).

3.1.7 Continuity of Care

Contractor must provide continuity of care to CCS-eligible Members transitioning to the Whole Child Model Program in accordance with W&I sections 14094.13, H&S section 1373.96, APL 21-005, and as follows:

A. In accordance with W&I section 14094.13(a)-(d), Contractor must ensure continuity of care between Members eligible for CCS and CCS Providers,

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and Providers of Specialized Durable Medical Equipment, with whom there is an existing relationship for up to 12 months after the transition.

B. For out-of-Network CCS Providers and Providers of Specialized Durable Medical Equipment, Contractor must provide continuity of care under the following conditions:

1) The Member has seen the CCS Provider for a non-emergency visit at least once during the 12 months immediately preceding their transition to the WCM program.

2) The Member has previously received Specialized Durable Medical Equipment from the Provider.

3) The CCS Provider or Provider of Specialized Durable Medical Equipment accepts Contractor's rate for the service, or the applicable Medi-Cal or CCS FFS rate, whichever is higher, unless the CCS Provider enters into an alternative payment methodology mutually agreed upon by Contractor and the CCS Provider.

4) Contractor confirms that the CCS Provider meets applicable CCS standards and has no disqualifying quality of care issues.

5) The CCS Provider makes treatment information available to Contractor, to the extent authorized by the State and federal patient privacy provisions.

6) The Provider of Specialized Durable Medical Equipment makes information available as requested by Contractor, to the extent authorized by the State and federal patient privacy provisions.

7) At its discretion, Contractor may extend the continuity of care period beyond the 12 months specified in Paragraph C.1) above.

C. Ensure that the continuity of care requirements for Pharmaceutical Services and Provision of Prescribed Drugs described in Exhibit A, Attachment III, Subsection 5.3.7.H (*Services for All Members*), are applied to Members who are eligible for the CCS program at the time of the transition to the WCM program. Before the previously prescribed drug is discontinued, Contractor and the Member's prescribing CCS Provider must complete the necessary evaluation and treatments, and must both agree that the previously prescribed drug is no longer Medically

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Necessary, or that it is no longer prescribed by the Member's prescribing CCS Provider.

D. For CCS neonatal intensive care units, Contractor must pay the Provider either the equivalent of Medi-Cal FFS rates, such as the All Patient Refined Diagnosis Related Group (APR-DRG) rates or other established rates, or Contractor's negotiated rate, whichever is higher, for up to 12 months after the transition.

3.1.8 EPSDT Services

For CCS-eligible Members, Contractor must provide all Medically Necessary Covered Services, including EPSDT services, as described in Exhibit A, Attachment III, Subsection 5.3.4.E (*Services for Members Less Than 21 Years of Age*), when the scope of an EPSDT benefit is more generous than the scope of a CCS benefit. In such cases, Contractor must apply the EPSDT standard of what is Medically Necessary to correct or ameliorate the Member's condition.

3.1.9 Care Management and Coordination of Care

In addition to the requirements in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*), and Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), Contractor must provide service authorization, case management, and Care Coordination for CCS by a primary point of contact with knowledge or adequate training on the CCS program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions. Once a Member's eligibility for the CCS program is established, Contractor must complete the following for risk stratification and assessment, and coordination of care in accordance with APL 21-005:

A. For Members identified as eligible for CCS, Contractor must conduct a Risk Stratification and Segmentation (RSS) in accordance with the requirements in Exhibit A, Attachment III, Subsection 4.3.5 (*Population Risk Stratification and Segmentation, and Risk Tiering*), and approved by DHCS to use for CCS-eligible Members. Based on the results of the health risk stratification, Contractor must then further assess CCS-eligible Members' risk levels and needs with an in-person or telephone communication, or an additional risk assessment approved by DHCS.

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B. For the transition of Members who are eligible for CCS and receiving services through the CCS program at the time of the transition, Contractor must conduct a RSS in accordance with the requirements of this Contract.

C. As determined necessary by Contractor's RSS, Contractor must provide Complex Care Management Services as described in Exhibit A, Attachment III, Subsection 4.3.7 (*Care Management Programs*), to all Members eligible for CCS and coordinate care between the Primary Care Provider (PCP), CCS specialty services, and if applicable Non-Specialty Mental Health Services and Regional Center services across all settings. The provision of Complex Care Management must include the facilitation of communication between the Member's health care Providers, personal care Providers such as IHSS, behavioral health Providers, and when appropriate, the Member and/or Member's parents, custodial parents, legal guardians, or other Authorized Representatives.

D. Contractor must also arrange referral to Specialty Mental Health and Drug Medi-Cal services as appropriate through the county Substance Use Disorder (SUD) program if determined necessary through Contractor's RSS. To arrange services with a Regional Center, Contractor must:

1) Coordinate with Members eligible for CCS and their parents, custodial parents, legal guardians, or other Authorized Representatives, in understanding and accessing services; and

2) Operate as a central point of contact for questions regarding access, care, and problem resolution.

E. Contractor must create a Care Management Plan (CMP) for CCS-eligible Members who have been determined high risk through the RSS process, incorporate the required elements stated in W&I section 14094.11I and APL 21-005, be specific to individual Member needs, and update the CMP at least annually.

F. Provide Person-Centered Planning, as described in Exhibit A, Attachment III, Subsection 5.2.12 (*Continuity of Care*), to Members eligible for CCS and in collaboration with the Member's parents, custodial parents, legal guardians, or other authorized representatives.

G. Provide information to Members eligible for CCS on how to access local family resource centers or family empowerment centers.

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H. Allow a Member eligible for CCS, or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives, to request continuing case management and Care Coordination from their public health nurse within 90 days of transitioning to the WCM program, in accordance with W&I section 14094.13(e). If the county public health nurse leaves the CCS program or is no longer available to provide case management and Care Coordination, Contractor must transition those services to one of its case managers who has received adequate training on the CCS program, and has clinical experience with the CCS population or pediatric patients with complex medical conditions.

I. If Contractor expands its CCS coverage area to other counties, Contractor must comply with CCS program standards including, but not limited to, referral standards as stated in W&I section 14093.06(a).

3.1.10 Rights for Members Eligible for CCS

A. Contractor must provide a mechanism for a Member eligible for CCS, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request a Specialist or clinic as a Primary Care Provider.

B. For Members receiving continuity of care as stated in Provision 5, Paragraph C of this Attachment, Contractor must send a written notice 60 days prior to the end of the authorized continuity of care period. The notice must explain the right to petition Contractor for an extension of the continuity of care period, the criteria used to evaluate the petition, and the Appeals process if Contractor denies the petition.

C. In addition to the Member's right to file a Grievance or request an Appeal, State Hearing, or an Independent Medical Review if applicable, as stated in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*), Contractor must also ensure that Members who are eligible for CCS, or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives, may Appeal the continuity of care limitations, or the extension of a continuity of care period, as stated in this Exhibit L, Subsection 3.1.6 (*Covered Services*), to the DHCS Director in accordance with W&I section 14094.13(i)(1).

D. Contractor must also ensure that CCS-eligible Members retain the right to request an Appeal and State Hearing for CCS eligibility and CCS service authorization denials.

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3.2 Required Reports for the Whole Child Model Program

In addition to the reporting requirements for Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) stated in Exhibit A, Attachment III, Section 7.0.(*Operations Deliverables and Requirements*), Contractor must also identify which Grievances and requests for Appeal were submitted by CCS-eligible Members.

3.3 Data Sharing Links

Contractor must establish and maintain communication links to allow interfaces with Children's Medical Services (CMS) Net and outside entities designated by DHCS.

3.3.1 Contractor must establish and maintain an agreement with the Office of Technology Services (Otech) within the California Department of Technology for an appropriate link between Contractor and Otech for the purpose of computer access for records contained in CMS Net and other Medi-Cal eligibility files that may be made available to Contractor. Upon connectivity with the authorized external entities, Contractor must retrieve information in a format to be determined by DHCS.

3.3.2 Contractor must comply with all data sharing requirements in Exhibit G of this Contract.

3.4 Whole Child Model Payments

Contractor must be paid a supplemental WCM monthly payment for each Member who is determined eligible for CCS. Payments for Members identified as CCS-eligible cannot exceed the rate as stated in Exhibit B, Section 1.3 (*Capitation Payment Rates*) and will be adjusted if DHCS has sent a separate rate payment for the Member for the same month of service. The payment period for the supplemental WCM payment must commence on the effective date of this Contract, January 1, 2024.

3.4.1 Contractor must receive the supplemental WCM payment in accordance with the conditions listed below.

A. The supplemental WCM payment must be in lieu of any other compensation for a CCS-eligible Member in any month.

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B. Contractor must be eligible to receive a supplemental WCM payment in the month in which a Member is determined to be eligible to receive CCS by the county CCS program.

3.4.2 If DHCS determines that a Member for whom Contractor received a supplemental WCM payment was not determined eligible for CCS in the month(s) for which supplemental WCM payment was made, DHCS must recover any amount improperly paid, by an offset to Contractor's capitation payment, in accordance with Exhibit B, Section 1.9 (*Recovery of Amounts Paid to Contractor*). DHCS must give Contractor 30 calendar days prior written notice of any such offset.

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CY 2024-B Contract Amendment Detail

Attachment to the June 5, 2025 Board of Directors Meeting – Agenda Item 4

Category	Requirement	Regulatory and Sub-Regulatory Guidance
Quality of Care for Children (p. 145)	-Outlines standard/electronic mailing requirements for Medi-Cal Kids and Teens materials.	-APL 23-005: Requirements For Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21
Network Provider Agreement Requirements with Safety Net Providers (pp. 176 – 177)	-Updated requirements regarding Network Provider Agreements with safety net providers including DHCS notification requirements for contract terminations.	
Community Supports (pp. 282 – 306)	-Provides the description of the 14 Community Supports definitions.	-Community Supports Policy Guide
Grievances and Appeals (p. 334)	-MCPs must submit grievance and appeal data to DHCS monthly.	-APL 20-017: Requirements for Reporting Managed Care Program Data
Member Rights and Responsibilities (pp. 342 – 343)	-Outlines member cost – sharing protections, including not holding members liable for the provisions outlined in this contract section and not billing members for covered services.	
Community Advisory Committee (CAC) (p. 388)	-MCPs must engage their CAC (i.e., MAC) as part of their participation in the Local Health Jurisdiction's (LHJ's) Community Health Assessment (CHAs) and Community Health Improvement Plans (CHIPs) process.	-Population Health Management Policy Guide
Network Certification Reports (p. 392)	-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
Memorandum of Understanding (MOU) Requirements (p. 465)	-MOUs must include 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.	-APL 23-029: Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities
Special Contract Provisions Related to Payment (p. 520)	-Removed Proposition 56 Directed Payments for Physician Services language due to Targeted Rate Increases (TRI).	-APL 24-007: Targeted Provider Rate Increases (TRI)
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	

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8437
Kelly Giardina, MSG, CCM, Executive Director, Clinical Operations, (657) 900-1013

Recommended Actions

Adopt Board Resolution No. 25-0605-01, authorizing and directing the Chair of the Board to execute Contract MS-2526-41 with the California Department of Aging for the Multipurpose Senior Services Program for Fiscal Year 2025-26.

Background

The Multipurpose Senior Services Program (MSSP) is a home and community-based services program, operated pursuant to a waiver in the State's Medi-Cal program. MSSP provides case management of social and health care as a cost-effective alternative to institutionalization of frail adults 60 years or older.

The California Department of Health Care Services (DHCS), through an Interagency Agreement, delegates the administration of the MSSP to the California Department of Aging (CDA). The CDA contracts with local government entities and private non-profit organizations for local administration of the MSSP in various areas of the state.

As the operator of the MSSP site for Orange County, CalOptima Health improves the quality of care for its aging population by linking frail adults, 60 years or older, to home and community-based services as an alternative to institutionalization and helps to contain long-term care costs by reducing unnecessary or inappropriate nursing facility placements. CalOptima Health has successfully implemented the MSSP program over the past 24 years for up to 568 members at any given point in time.

Discussion

CalOptima Health has received the CDA contract MS-2526-41 for execution by the Chair of the CalOptima Health Board of Directors (Board), which, upon the adoption of a resolution and execution of the contract, will extend the MSSP through June 30, 2026, with the maximum total of the contract set at $3,042,208.

The attached CDA Contract includes a Summary of Changes. Note the following substantive changes: (i) MSSP age eligibility requirement has been lowered from sixty-five (65) to sixty (60) or older; (ii) the MSSP qualifying aid code list has expanded; and (iii) the MSSP site no longer makes eligibility determinations, but is now required to predetermine participant eligibility and submit required documentation to CDA for review. The final determination of eligibility will be made by CDA MSSP

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Bureau nurses, using assessment(s) and level of care form completed by the site care management team. The date of submission (once approved) is participant enrollment date.

The scope of work and other obligations are consistent with existing contract obligations. The waiver number under which CDA contract MS-2526-41 is issued remains as CA.0141.R07.00, which is effective for a five (5)-year period beginning July 1, 2024.

Fiscal Impact
Staff has incorporated projected revenue and expense related to the MSSP in the CalOptima Health Fiscal Year (FY) 2025-26 Operating Budget, pending Board approval.

Rationale for Recommendation
Adoption of Board Resolution No. 25-0605-01, authorizing and directing the Chair of the Board to execute the FY 2025-26 contract with the CDA for the MSSP will allow CalOptima Health to continue to address the long-term community care needs of some of CalOptima Health's frailest members, 60 years or older, by helping them to remain in their homes.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Board Resolution No. 25-0605-01, Execute Contract No. MS-2526-41 with the State of California Department of Aging for the Multipurpose Senior Services Program.
2. MSSP Contract No. MS-2526-41

/s/ Michael Hunn *05/29/2025*
Authorized Signature **Date**

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RESOLUTION NO. 25-0605-01

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY
Orange Prevention and Treatment Integrated Medical Assistance
d.b.a. CalOptima Health

EXECUTE CONTRACT NO. No. MS-2526-41
WITH THE STATE OF CALIFORNIA
DEPARTMENT OF AGING FOR THE
MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

WHEREAS, the Orange County Health Authority, d.b.a. CalOptima Health ("CalOptima Health") continues to provide services as a Multipurpose Senior Service Program Site under contract with the California Department of Aging;

WHEREAS, the California Department of Aging notified CalOptima Health of its intent to contract for the assignment of 568 MSSP participant slots to CalOptima Health;

WHEREAS, the California Department of Aging has requested the execution of Contract MS-2526-41; and

WHEREAS, the Board of Directors has determined that it is in the best interest of the ongoing development of CalOptima Health home and community-based services to the Medi-Cal beneficiaries residing in Orange County to approve CalOptima Health executing Contract MS-2526-41.

NOW, THEREFORE, BE IT RESOLVED:

I. That CalOptima Health is hereby authorized to enter into Contract MS-2526-41 with the California Department of Aging on the terms and conditions set forth in the form provided to the Board of Directors; and

II. That the Chair of the Board of Directors is hereby authorized and directed to execute and deliver Contract MS-2526-41 by and on behalf of CalOptima Health on the terms and conditions set forth in the form provided to the Board of Directors.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 5th day of June 2025.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Isabel Becerra, Chair, Board of Directors

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

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All documents listed are required to execute your contract unless otherwise noted.

- All documents must identify the Contractor's legal name exactly as shown on the standard agreement or amendment (STD. 213 or 213A).
- Contract packages must be complete and able to stand alone. For example, if you have more than one contract with the California Department of Aging (CDA),you may have one Insurance Certificate to cover all contracts but must include a copy of the Certificate in each contract package returned to CDA.
- This checklist does not need to be submitted as part of the contract package.
- **Return final contract packages to:**
  California Department of Aging
  Attn: Contract Analyst
  2880 Gateway Oaks Drive, Suite 200
  Sacramento, CA 95833

  Or by email at BMBSubvention@aging.ca.gov

☐ **Two (2) Standard Agreements or Amendments (STD. 213 or 213A)** – Print, sign and submit four copies of the Std. 213 or 213A (signature page) with ***original signatures*** (Blue ink is preferable). Signature stamps or copies of any type will not be accepted. CDA can provide documents for signature via DocuSign. This option must be requested via email at BMBSubvention@aging.ca.gov

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- ☐ **Agreement Authorization Document** – Submit a signed Board Resolution, Order, or Meeting Minutes that demonstrates the Organization's approval of each contract. The contract number(s) must be referenced in the document. If the document does not demonstrate authorization to sign amendments, another authorization document will be needed to amend the contract. If Board Meeting Minutes are used, they must be signed off as approved or the following Board Meeting Minutes must be submitted showing the previous Board Meeting Minutes were approved. For local governments and public entities, authorization is required from the Board of Supervisors or equivalent governing body. For Nonprofits, authorization is required from the Board of Directors. [See MSSP Contract, Exhibit D, Article II, Section K.]

- ☐ **Information Integrity and Security Statement (CDA 1024)** – Print, sign and submit one copy of the CDA 1024 for each contract. The contract number must be referenced on the document. Resubmission of this document is not required for amendments. [See MSSP Contract, Exhibit D, Article XVII, Section F.]

- ☐ **Contractor Certification Clauses (CCC 4/2017)** – Print, sign, and submit a signed copy of the CCC 4/2017 certification, certifying your organization's compliance. Resubmission of this document is not required for amendments. [See MSSP Contract Exhibit D, Article II, Section C.3]

- ☐ **California Civil Rights Laws Certification (CDA 9026)** – Print, sign and submit a signed copy of the CDA 9026 certification, certifying your organization's compliance. Resubmission of this document is not required for amendments. [See MSSP Contract Exhibit D, Article II, Section C.3]

- ☐ **Insurance Requirements** – Submit a Certificate of Insurance or Letter of Self-Insurance for each contract. Insurance document(s) are required and must meet the General, Automobile and Professional liability coverages and conditions in the contract. The Certificate or Letter of Self Insurance must reference the contract number(s) and demonstrate coverage for the entire term of the Contract. General and Automobile Liability coverage requires an additional insured statement naming the State of California as an additional insured entity. Resubmission of this document is not required for amendments. [See MSSP contract Exhibit D, Article XI.]

STATE OF CALIFORNIA – DEPARTMENT OF GENERAL SERVICES

STANDARD AGREEMENT
STD 213 (Rev. 04/2020)

SCO ID: 4260-MS252641

AGREEMENT NUMBER	PURCHASING AUTHORITY NUMBER (If Applicable)
MS-2526-41	

1. This Agreement is entered into between the Contracting Agency and the Contractor named below:

CONTRACTING AGENCY NAME
California Department of Aging

CONTRACTOR NAME
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA

2. The term of this Agreement is:

START DATE
07/01/2025

THROUGH END DATE
06/30/2026

3. The maximum amount of this Agreement is:
$ 3,042,208 Three Million, Forty Two Thousand, Two Hundred Eight and 00/100 Dollars

4. The parties agree to comply with the terms and conditions of the following exhibits, which are by this reference made a part of the Agreement.

Exhibits		Title	Pages
	Exhibit A	Scope of Work	18 pages
	Exhibit A, Attachment 1	General Information	1 page
	Exhibit B	Budget Detail and Payment Provisions	7 pages
	Exhibit B, Attachment 1	Budget Display	1 page
	Exhibit C	General Terms and Conditions – GTC-4/2017*	0 pages
	Exhibit D	Special Terms and Conditions	34 pages
	Exhibit E	Additional Provisions Specific to this MSSP Agreement	7 pages
	Exhibit F	HIPPA Business Associates Addendum	7 pages
	Exhibit G	Catchment Area Zip Codes	1 page

Items shown with an asterisk (*), are hereby incorporated by reference and made part of this agreement as if attached hereto.
These documents can be viewed at https://www.dgs.ca.gov/OLS/Resources

IN WITNESS WHEREOF, THIS AGREEMENT HAS BEEN EXECUTED BY THE PARTIES HERETO.

CONTRACTOR

CONTRACTOR NAME (if other than an individual, state whether a corporation, partnership, etc.)
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA

CONTRACTOR BUSINESS ADDRESS	CITY	STATE	ZIP
505 City Parkway West	Orange	CA	92868

PRINTED NAME OF PERSON SIGNING	TITLE
Isabel Beerra	Chair, Board of Directors

CONTRACTOR AUTHORIZED SIGNATURE	DATE SIGNED

STATE OF CALIFORNIA

CONTRACTING AGENCY NAME
California Department of Aging

CONTRACTING AGENCY ADDRESS	CITY	STATE	ZIP
2880 Gateway Oaks Drive, Suite 200	Sacramento	CA	95833

PRINTED NAME OF PERSON SIGNING	TITLE
Andy Sachs	Assistant Deputy Director

CONTRACTING AGENCY AUTHORIZED SIGNATURE	DATE SIGNED

CALIFORNIA DEPARTMENT OF GENERAL SERVICES APPROVAL	EXEMPTION (If Applicable)
	AG OP 80-111

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Contractor Certification Clauses

CCC 04/2017

CERTIFICATION

I, the official named below, CERTIFY UNDER PENALTY OF PERJURY that I am duly authorized to legally bind the prospective Contractor to the clause(s) listed below. This certification is made under the laws of the State of California.

Contractor/Bidder Firm Name (Printed)	Federal ID Number
Orange CO Health Agency, DBA CalOptima Health	33059989 1

By (Authorized Signature)

Printed Name and Title of Person Signing

Isabel Becerra, Chair, Board of Directors

Date Executed	Executed in the County of
	Orange

CONTRACTOR CERTIFICATION CLAUSES

1. STATEMENT OF COMPLIANCE: Contractor has, unless exempted, complied with the nondiscrimination program requirements. (Gov. Code §12990 (a-f) and CCR, Title 2, Section 11102) (Not applicable to public entities.)

2. DRUG-FREE WORKPLACE REQUIREMENTS: Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.

b. Establish a Drug-Free Awareness Program to inform employees about:

1) the dangers of drug abuse in the workplace;

2) the person's or organization's policy of maintaining a drug-free workplace;

3) any available counseling, rehabilitation and employee assistance programs; and,

4) penalties that may be imposed upon employees for drug abuse violations.

c. Every employee who works on the proposed Agreement will:

1) receive a copy of the company's drug-free workplace policy statement; and,

2) agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and Contractor may be ineligible for award of any future State agreements if the department determines that any of the following has occurred: the Contractor has made false certification, or violated the certification by failing to carry out the requirements as noted above. (Gov. Code §8350 et seq.)

3. NATIONAL LABOR RELATIONS BOARD CERTIFICATION: Contractor certifies that no more than one (1) final unappealable finding of contempt of court by a Federal court has been issued against Contractor within the immediately preceding two-year period because of Contractor's failure to comply with an order of a Federal court, which orders Contractor to comply with an order of the National Labor Relations Board. (Pub. Contract Code §10296) (Not applicable to public entities.)

4. CONTRACTS FOR LEGAL SERVICES $50,000 OR MORE- PRO BONO REQUIREMENT: Contractor hereby certifies that Contractor will comply with the requirements of Section 6072 of the Business and Professions Code, effective January 1, 2003.

Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lessor of 30 multiplied by the number of full time attorneys in the firm's offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

5. EXPATRIATE CORPORATIONS: Contractor hereby declares that it is not an expatriate corporation or subsidiary of an expatriate corporation within the meaning of Public Contract Code Section 10286 and 10286.1, and is eligible to contract with the State of California.

6. SWEATFREE CODE OF CONDUCT:

a. All Contractors contracting for the procurement or laundering of apparel, garments or corresponding accessories, or the procurement of equipment, materials, or supplies, other than procurement related to a public works contract, declare under penalty of perjury that no apparel, garments or corresponding accessories, equipment, materials, or supplies furnished to the state pursuant to the contract have been laundered or produced in whole or in part by sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor, or with the benefit of sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor. The contractor further declares under penalty of perjury that they adhere to the Sweatfree Code of Conduct as set forth on the California Department of Industrial Relations website located at www.dir.ca.gov, and Public Contract Code Section 6108.

b. The contractor agrees to cooperate fully in providing reasonable access to the contractor's records, documents, agents or employees, or premises if reasonably

required by authorized officials of the contracting agency, the Department of Industrial Relations, or the Department of Justice to determine the contractor's compliance with the requirements under paragraph (a).

7. DOMESTIC PARTNERS: For contracts of $100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.3.

8. GENDER IDENTITY: For contracts of $100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.35.

DOING BUSINESS WITH THE STATE OF CALIFORNIA

The following laws apply to persons or entities doing business with the State of California.

1. CONFLICT OF INTEREST: Contractor needs to be aware of the following provisions regarding current or former state employees. If Contractor has any questions on the status of any person rendering services or involved with the Agreement, the awarding agency must be contacted immediately for clarification.

Current State Employees (Pub. Contract Code §10410):

1). No officer or employee shall engage in any employment, activity or enterprise from which the officer or employee receives compensation or has a financial interest and which is sponsored or funded by any state agency, unless the employment, activity or enterprise is required as a condition of regular state employment.

2). No officer or employee shall contract on his or her own behalf as an independent contractor with any state agency to provide goods or services.

Former State Employees (Pub. Contract Code §10411):

1). For the two-year period from the date he or she left state employment, no former state officer or employee may enter into a contract in which he or she engaged in any of the negotiations, transactions, planning, arrangements or any part of the decision-making process relevant to the contract while employed in any capacity by any state agency.

2). For the twelve-month period from the date he or she left state employment, no former state officer or employee may enter into a contract with any state agency if he or she was employed by that state agency in a policy-making position in the same general subject area as the proposed contract within the 12-month period prior to his or her leaving state service.

If Contractor violates any provisions of above paragraphs, such action by Contractor shall render this Agreement void. (Pub. Contract Code §10420)

Members of boards and commissions are exempt from this section if they do not receive payment other than payment of each meeting of the board or commission, payment for preparatory time and payment for per diem. (Pub. Contract Code §10430 (e))

2. LABOR CODE/WORKERS' COMPENSATION: Contractor needs to be aware of the provisions which require every employer to be insured against liability for Worker's Compensation or to undertake self-insurance in accordance with the provisions, and

Contractor affirms to comply with such provisions before commencing the performance of the work of this Agreement. (Labor Code Section 3700)

3. AMERICANS WITH DISABILITIES ACT: Contractor assures the State that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. (42 U.S.C. 12101 et seq.)

4. CONTRACTOR NAME CHANGE: An amendment is required to change the Contractor's name as listed on this Agreement. Upon receipt of legal documentation of the name change the State will process the amendment. Payment of invoices presented with a new name cannot be paid prior to approval of said amendment.

5. CORPORATE QUALIFICATIONS TO DO BUSINESS IN CALIFORNIA:

a. When agreements are to be performed in the state by corporations, the contracting agencies will be verifying that the contractor is currently qualified to do business in California in order to ensure that all obligations due to the state are fulfilled.

b. "Doing business" is defined in R&TC Section 23101 as actively engaging in any transaction for the purpose of financial or pecuniary gain or profit. Although there are some statutory exceptions to taxation, rarely will a corporate contractor performing within the state not be subject to the franchise tax.

c. Both domestic and foreign corporations (those incorporated outside of California) must be in good standing in order to be qualified to do business in California. Agencies will determine whether a corporation is in good standing by calling the Office of the Secretary of State.

6. RESOLUTION: A county, city, district, or other local public body must provide the State with a copy of a resolution, order, motion, or ordinance of the local governing body which by law has authority to enter into an agreement, authorizing execution of the agreement.

7. AIR OR WATER POLLUTION VIOLATION: Under the State laws, the Contractor shall not be*:* (1) in violation of any order or resolution not subject to review promulgated by the State Air Resources Board or an air pollution control district; (2) subject to cease and desist order not subject to review issued pursuant to Section 13301 of the Water Code for violation of waste discharge requirements or discharge prohibitions; or (3) finally determined to be in violation of provisions of federal law relating to air or water pollution.

8. PAYEE DATA RECORD FORM STD. 204: This form must be completed by all contractors that are not another state agency or other governmental entity.

STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
INFORMATION INTEGRITY AND SECURITY STATEMENT
CDA 1024 (REV 03/2020)

In compliance with California Government Code Section 11019.9, California Civil Code Section 1798 et seq., Department of General Services Management Memo 06-12, and Statewide Information Management Manual (SIMM) 5300 the California Department of Aging (CDA) hereby requires the Contractor/Vendor to:

ACKNOWLEDGE:

- Any wrongful access, inspection, use, or disclosure of Personal, Confidential or Sensitive Information (PSCI) is a crime and is prohibited under state and federal laws, including but not limited to California Penal Code Section 502, California Government Code Section 15619, California Civil Code Section 1798.53 and 1798.55, and the Health Insurance Portability and Accountability Act. Acknowledge.
- Any wrongful access, inspection, use, disclosure, or modification of PSCI information may result in termination of this Contract/Agreement.

MEET THE FOLLOWING REQUIREMENTS:

- PSCI information shall be protected from disclosure in accordance with all applicable laws, regulations, and policies.
- PSCI data be protected by authorized access using the principles of least privilege.
- Any occurrence that actually or potentially jeopardizes the confidentiality, integrity, or availability of an information system or the information the system processes, stores, or transmits or that constitutes a violation or imminent threat of violation of security policies, security procedures or acceptable use policies will immediately be reported to CDA by completing a Security Incident Report CDA (1025A and 1025B).
- All access codes which allow access to confidential information will be properly safeguarded.
- Obligations to protect PSCI information obtained under this Contract/Agreement will continue after termination of the Contract/Agreement with CDA.
- All employees/subcontractors of the Contractor/Vendor will complete the required Security Awareness Training module located at https://aging.ca.gov/Information_security/ within 30 days of the start date of the Contract/Agreement or within 30 days of the start date of any new employee or subcontractor. This training must be completed annually.
- All employees/subcontractors of the Contractor/Vendor must comply with CDA's confidentiality and data security requirements as outlined in the Contract/Agreement.
- All employees/subcontractors of the Contract/Vendor must comply with the Appendix D, section XVIII encryption and self-certification requirements as outlined in the contract.

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STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
INFORMATION INTEGRITY AND SECURITY STATEMENT
CDA 1024 (REV 03/2020)

CERTIFY:

To protect PSCI information by:

- Accessing, inspecting, using, disclosing or modifying PSCI information only for the purpose of performing official duties.
- Never accessing, inspecting, using, disclosing, or modifying PSCI information for curiosity, personal gain, or any non-business-related reason.
- Securing PSCI information in approved locations.
- Never removing PSCI information from the work site without authorization.

Meets the encryption requirements in Exhibit D Article 18:

☑ Is in full compliance with the 128 Encryption requirements.

☐ Is not in compliance with the 128 Encryption requirements and will achieve compliance by _____.

I hereby certify that I have reviewed this Confidentiality Statement and will comply with the above statements.

OC Health Authority, DBA CalOptima Health / Isabel Becerra, Chair, Board of Directors
Contractor/Vendor Printed Name and Title

Contractor/Vendor Signature

Date

CDA Program/Project

MS-2526-41
Contract Number

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STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
CALIFORNIA CIVIL RIGHTS LAWS CERTIFICATION
CDA 9026 (NEW 04/2018)

Pursuant to Public Contract Code section 2010, a person that submits a bid or proposal to, or otherwise proposes to enter into or renew a contract with, a state agency with respect to any contract in the amount of $100,000 or above shall certify, under penalty of perjury, at the time the bid or proposal is submitted or the contract is renewed, all of the following:

1. CALIFORNIA CIVIL RIGHTS LAWS: For contracts executed or renewed after January 1, 2017, the contractor certifies compliance with the Unruh Civil Rights Act (Section 51 of the Civil Code) and the Fair Employment and Housing Act (Section 12960 of the Government Code); and

2. EMPLOYER DISCRIMINATORY POLICIES: For contracts executed or renewed after January 1, 2017, if a Contractor has an internal policy against a sovereign nation or peoples recognized by the United States government, the Contractor certifies that such policies are not used in violation of the Unruh Civil Rights Act (Section 51 of the Civil Code) or the Fair Employment and Housing Act (Section 12960 of the Government Code).

CERTIFICATION

I, the official named below, certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Contractor Name (Printed): Orange CO Health Agency, DBA CalOptima	Federal ID Number: 33059989 1
By (Authorized Signature):	
Printed Name and Title of Person Signing: Isabel Becerra, Chair, Board of Directors	
Date Executed:	Executed in the County and State of: Orange

Indicate all California Department of Aging contracts your organization participates in:

- ☐ Area Plan (AP)
- ☐ Financial Alignment (FA)
- ☐ HICAP (HI)
- ☐ MIPPA (MI)
- ☑ MSSP (MS)
- ☐ SNAP-Ed (SP)
- ☐ Title V (TV)

STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
MSSP AGENCY CONTRACTS REPRESENTATIVE (ACR)
CDA 9028 (NEW 03/2020)

MSSP Site Number(s): 41	Submission Date:

CONTRACTOR INFORMATION:	*** Change Requires STD 204**
*Legal Name: Orange County Health Authority	
*DBA Name: CalOptima Health	
*Business Address: 505 City Parkway West	City, State, Zip: Orange, CA 92869
*Mailing Address: Same as above	City, State, Zip:
General Email: erounds@caloptima.org	Website: caloptima.org
Public Line: (714) 246-8400	Fax:

ACR CONTACT INFORMATION:		
First Name: Evelyn	Last Name: Rounds	Title: Site Director
Email: erounds@caloptima.org	Business: (714) 246-8773	Fax: (714) 338-3107
Role: MSSP Agency Contract Representative Site Director		

PROJECT REPRESENTATIVE CONTACT INFORMATION:		
First Name: Scott	Last Name: Robinson	Title: Director, LTSS
Email: scott.robinson@caloptima.org	Business: (657) 900-1457	Fax:
Role: ☐ MSSP Site Director ☐ Program Director		

Authorized Signature: Evelyn Rounds, LCSW Print Name: Evelyn Rounds

Title: Site Director Phone: (714) 246-8773 Date: 04/29/25

Once completed, email this form to CDA Business Services: CDABusinessServices@aging.ca.gov.

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STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
MSSP AGENCY CONTRACTS REPRESENTATIVE (ACR)
CDA 9028 (NEW 03/2020)

Background and Instructions

What we are requesting from you and why?

The California Department of Aging (CDA) is requesting that you fill in the Authorized Contract Representative (ACR) Form to update CDA's MSSP contract contact database. The information collected is placed in your MSSP Site contract with CDA.

Who is the ACR and what do they do?

The ACR is the person designated by the MSSP site to handle all questions regarding the documents needed to execute a MSSP contract. The ACR will be the person CDA contacts first to handle any documents required to complete final execution of your MSSP Contract.

The ACR may be anyone ranging from a site Director to site support staff. The ACR is not required to be the person who signs (Director, Board Member) the contract. This allows the Contractor the flexibility to designate a separate staff member to bring together required contract documents, gather required signatures and mail final documents to CDA.

Who is the Project Representative and what do they do?

The Project Representative is the person designated by the MSSP site to handle all questions regarding the MSSP contracted services. The Project Representative manages the contract at service level and works with CDA MSSP staff regarding performance of the contracted services, etc. Other names for a Project Representative may be Contract/Program Administrator/Manager.

The Project Manager is typically a Site Director or Upper level Manager directly supervising services or sub-contracts.

How often is this form completed?

This form is completed on a yearly basis or as needed. CDA will send out ACR form requests once per year or upon a change request by a MSSP site.

May I designate a separate ACR for my AAA and MSSP contracts?

Yes, if your organization participates in both AAA programs and the MSSP Program, you will designate an ACR as follows:

- For AAA Programs use CDA 045 process outlined in your AAA contracts (Exhibit D, Article XVII, Section B)
- For MSSP use CDA 9028 MSSP process outlined in your MSSP contract (Exhibit D, Article XVII, Section B)

Additional Questions?

Additional questions are encouraged! If you have any additional questions, please feel free to contact me at CDABusinessService@aging.ca.gov, by replying to my original e-mail request, or by phone at (916) 419-7157.

STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING

CONTRACT SUMMARY OF CHANGES

CDA 9008 (NEW 6/16)

Program: CDA-MSSP

Contract Number: MS2526

Contract Term: Fiscal Year July 2025- June 2026

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
EXAMPLE:	**EXAMPLE:** n/a	**EXAMPLE:** c) Include staff timesheets that detail how much time is spent on each activity.	**EXAMPLE:** New regulatory language added by the CA Dept. of Oversight	**EXAMPLE:** Sam Smith
Exhibit A, Article I.	Home and Community Based Services Waiver, Control Number CA.0141.R07.00…….(HCBS Waiver)	Home and Community Based Services (HCBS) Waiver, Control Number CA.0141.R07.00	Updated hyperlink to correct waiver Also moved HCBS acronym to after the first use of HCBS	Amber Kraw MSSP Policy
Exhibit A, Article I.	age sixty-five (65) or older; meet the eligibility criteria as a Medi-Cal recipient with an eligible Medi-Cal Aid Code I; and be certifiable for placement in a nursing facility; live within a site's catchment area; be	age sixty (60) or older; meet the eligibility criteria as a Medi-Cal recipient with an eligible Medi-Cal Aid Code be certifiable for placement in a nursing facility; live within a site's catchment area; be	Updating eligibility from 65 to 60 and removing catchment area language for clarity.	Amber Kraw MSSP Policy
Exhibit A, Article II.	Determining eligibility	predetermining eligibility,	Adjusting contractor requirements as a result of the new LOC process	MSSP Program
Exhibit A, Article II.A.2.	The care management team shall determine waiver participant eligibility based on the criteria specified in the MSSP Site Manual, herein incorporated by reference	The care management team shall predetermine waiver participant eligibility based on the criteria specified in the MSSP Site Manual, herein incorporated by reference, then submit all required documentation to CDA for review. The final determination of eligibility will be made by CDA MSSP Bureau nurses, using assessment(s)	Adjusting contractor requirements as a result of the new LOC process	MSSP Program

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Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
		and the Level of Care (LOC) form completed by the site care management team.		
Exhibit A, Article II.C.4.	The Contractor shall assure that its subcontractors have the license(s), credentials, qualifications or experience to provide services to the MSSP participant.	The Contractor shall assure that its subcontractors have the license(s), credentials, training, qualifications or experience to provide services to the MSSP participant.	Added training to be included in expectations for subcontractors.	MSSP Program
Exhibit A, Article II.D.4.	Level of Care (LOC) that a MSSP applicant or MSSP waiver participant meets the requirement(s) for nursing facility placement.	Finalized Level of Care (LOC) form that contains the approval signature of a CDA MSSP Bureau nurse, certifying certification by the Contractor that a MSSP Applicant or MSSP waiver participant meets the requirement(s) for nursing facility placement.	Adjusting contractor requirements as a result of the new LOC process	MSSP Program
Exhibit A, Article II.E.2.a	Waiver participant name, MSSP waiver participant number, Medi-Cal aid code, county code, Medicare and Social Security numbers, birth date, level of care, emergency contact information, physician information, and demographic information	Waiver participant name, MSSP waiver participant number, Medi-Cal aid code, county code, Medicare and Social Security numbers, birth date, emergency contact information, physician information, and demographic information	Removed Level of Care as a requirement for the contractor to maintain as a result of the new LOC process.	MSSP Program
Exhibit A, Article II.E.5.	Submit to CDA by the 5th working day of the month (unless otherwise specified by CDA), the active waiver participant count for the preceding month. The active waiver participant count consists of the number of waiver	Submit to CDA by the 5th working day of the month (unless otherwise specified by CDA), the active waiver participant count for the preceding month. The active waiver participant count consists of the number of	Adjusting contractor requirements as a result of the new LOC process	MSSP Program

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
	participants actively enrolled in MSSP on the last (business) day of the reporting month. This does not include waiver participant cases closed (or terminated) during the reporting month.	waiver participants actively enrolled in MSSP on the last (business) day of the reporting month. This includes applicants with a LOC determination submitted to CDA pending approval but does not include waiver participant cases closed (or terminated) during the reporting month.		
Exhibit A, Article II.F	If the Contractor's active participant count falls below ninety-five percent (95%) of the number of budgeted participant slots for more than three (3) consecutive months, the Contractor shall be required to submit an enrollment plan for review, approval, and monitoring by CDA.	If the Contractor's active participant count falls below ninety-five percent (95%) of the number of budgeted participant slots for more than three (3) consecutive months, the Contractor shall be required to submit a Corrective Action Plan for review, approval, and monitoring by CDA.	Adding Corrective Action Plan language	MSSP Program/Policy
Exhibit A, Article II.F.1.a-b & Exhibit A, Article II.F.2.a	New section added	1. Voluntarily Relinquishing Slots a. At any time and for any reason, a Contractor may voluntarily request to return slots in increments of 10, preferably 40. b. A Contractor may initiate the slot relinquishment process by notifying CDA in writing.	Added language allowing sites to request/relinquish participant slots	MSSP Program

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
		2. Request for Additional Slots a. A Contractor operating at 95% enrollment or higher may submit a written request for additional slots. The Contractor can request slots in increments of 40. CDA will notify the Contractor of its determination within 60 days.		
Exhibit A, Article II.H.4.	The Contractor shall serve participants in the Catchment Area as defined in Exhibit G of this Agreement.	The Contractor shall serve participants in the Catchment Area as defined in Exhibit G of this Agreement. Any revisions to Exhibit G require CDA approval.	Including a provision to ensure zip code catchment expansion is previously approved by CDA	MSSP Program
Exhibit A, Article III.1	**Adult Day Care** (1.1): Will be provided to MSSP waiver participants who are identified in their plan of care as benefiting from being in a social setting with less intense supervision and fewer professional services than offered in an adult day health support center. Adult Day Care services will be provided when the waiver participant's plan of care indicates that the service is necessary to reach a therapeutic goal or provide respite for the family or caregiver.	**Adult Day Care** (1.1): Will be provided when the waiver participant's plan of care indicates that the service is necessary to reach a therapeutic goal or provide respite for the family or caregiver.	Definition adjustment	MSSP Program

STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
CONTRACT SUMMARY OF CHANGES
CDA 9008 (NEW 6/16)

Program: CDA-MSSP
Contract Number: MS2526
Contract Term: Fiscal Year July 2025- June 2026

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
Exhibit A, Article III.3	3. **Non-medical Home Equipment** (2.3): Includes equipment and supplies which address a waiver participant's functional limitation and/or condition, are necessary to assure the waiver participant's health, safety, and independence, and are not otherwise provided through this Waiver or through the State Plan. Allowable items: Small appliances; large appliances; furniture; home safety devices; clothing-related items; paperwork-related items; organizing items; household items (items that are not specifically designed for home safety, but are necessary to maintain independence and safety in the home); kitchenware; bedding/bath items; exercise equipment; social support/therapeutic activity supplies; personal care items (items related to personal care and the prevention of skin breakdown); health-related supplies (items that have a health component, but are not covered by the	3. **<u>Specialized</u> Non-medical Home Equipment** (2.3): Includes equipment and supplies which address a waiver participant's functional limitation and/or condition, are necessary to assure the waiver participant's health, safety, and independence, and are not otherwise provided through this Waiver or through the State Plan. Allowable items: • Small appliances • Large appliances • Furniture • Home safety devices • Clothing related items (Must stem from a medical or functional need) • Paperwork related/ Organizing items • Household items (Items that are not specifically designed for home safety, but are necessary to maintain independence and safety in the home) • Kitchenware	Addition of the word specialized. Formatting to include bullets.	MSSP Program

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Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
	State Plan); and incontinence supplies (gloves, wipes, washcloths and creams).	• Bedding/Bath items • Exercise equipment • Social support/ Therapeutic activity supplies • Personal care items (Items related to personal care and the prevention of skin breakdown) • Health related supplies (Items that have a health component, but are not covered by the State Plan) • Incontinence supplies (gloves, wipes, washcloths, and creams)		
Exhibit A, Article III.4	**Community Transition Services-** (2.4): These services allow for non-recurring moving and/or set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community.	**Community Transition Services-** (2.4): These services allow for non-recurring moving and/or housing set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community.	Inclusion of the word housing	MSSP Program
Exhibit A, Article III.4		Community Transition Services are furnished only to the extent that they are reasonable and necessary, determined through the care plan development process, clearly identified in the care plan and the person is	New language to ensure Community Transitions are not duplicated by other services	MSSP Program

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
		unable to meet such expenses or when the services cannot be obtained from other sources.		
Exhibit A, Article III.5	Assistive Technology includes: (A) the evaluation of the assistive technology needs of a waiver participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the waiver participant	Assistive Technology includes: (A) the evaluation of the assistive technology needs of a waiver participant, which is performed and billed under the MSSP care management service. The evaluation includes a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the waiver participant	Adds language clarifying that Assistive Technology is performed and billed under MSSP Care Management Service.	MSSP Program
Exhibit A, Article III.6	The Care manager completes a health and psychosocial assessment which assess all waiver participant needs including the need for homemaker services and personal care. The assessments also consider IHSS services in place and whether the waiver participant's needs are being met.	6. Supplemental Services (3.1, 3.2, and 3.7): These services are for purposes of household support, personal care, and protective supervision for those services above and beyond those available through the In-Home Supportive Services (IHSS) Program or to participants that are not eligible for IHSS. Examples include:	This was removed in previous versions of the contract to save space; however, then this information is repeated for 3.1, 3.2 and 3.7. Returning preface to be consistent with the format of other grouped services and reduce duplication of	MSSP Program

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
		1. The MSSP participant has not yet been assessed for IHSS and needs services in the interim until IHSS can be arranged. 2. The regular IHSS provider is not available and IHSS cannot provide a substitute. 3. IHSS services are in place; however, MSSP has assessed a greater need. In these cases, MSSP will advocate with IHSS for increased time for those services before authorizing expenditure of Waiver funds. Services purchased can supplement but not supplant IHSS.	information below [in the document].	
Exhibit A, Article III.6	New Section	Supplemental Homemaker, Personal Care, and Protective Supervision services shall be subject to Electronic Visit Verification (EVV) requirements required by Subsection (l) of Section 1903 of the Social Security Act	EVV requirements	MSSP Program

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
		(SSA) (42 U.S.C. 1396b). Vendor contracts for 3.1, 3.2, and 3.7 services must contain language that addresses EVV requirements.		
Exhibit A, Article III.6	a. Supplemental Homemaker Services (3.1): are for purposes of household support and applies to the performance of household tasks rather than to the care of the waiver participant. Homemaker activities are limited to: household cleaning, laundry (including the services of a commercial laundry or dry cleaner), shopping, food preparation, and household maintenance. waiver participant instruction in performing household tasks and meal preparation may also be provided. Supplemental Homemaker Services under the MSSP Waiver are limited to additional services not otherwise covered under the State Plan or under IHSS, but consistent with the Waiver objectives of avoiding institutionalization.	a. Supplemental Homemaker Services (3.1): are for purposes of household support and applies to the performance of household tasks rather than to the care of the waiver participant. Homemaker activities are limited to: household cleaning, laundry (including the services of a commercial laundry or dry cleaner), shopping, food preparation, and household maintenance. Waiver Instruction in performing household tasks may also be provided. a. Supplemental Personal Care (3.2): This service provides assistance to maintain bodily hygiene, personal safety, and activities of daily living (ADL). These tasks are limited to non-medical	Removed language for clarity	MSSP Program

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
	Services purchased using 3.1 can supplement but not supplant IHSS. a. Supplemental Personal Care (3.2): This service provides assistance to maintain bodily hygiene, personal safety, and activities of daily living (ADL). These tasks are limited to non-medical personal services: feeding, bathing, oral hygiene, grooming, dressing, care of and assistance with prosthetic devices, rubbing skin to promote circulation, turning in bed and other types of	personal services: feeding, bathing, oral hygiene, grooming, dressing, care of and assistance with prosthetic devices, rubbing skin to promote circulation, turning in bed and other types of		
Exhibit A, Article III.6	b. repositioning, assisting the individual with walking, and moving the individual from place to place (e.g., transferring). waiver participant instruction in self-care may also be provided; may also include assistance with preparation of meals but does not include the cost of the meals themselves. Supplemental Personal Care under the MSSP Waiver is limited to additional	Supplemental Protective Supervision (3.7): Ensures provision of supervision in the absence of the usual care provider to persons residing in their own homes, who are very frail or otherwise may suffer a medical emergency. Such supervision serves to prevent immediate placement in an acute care hospital, skilled nursing facility, or other 24-hour care facility. Such supervision does	Removed language for clarity	MSSP Program

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
	services not otherwise covered under the State Plan or under IHSS, but consistent with the Waiver objectives of avoiding institutionalization. Services are provided when personal care services furnished under the approved State Plan limits are exhausted. The scope and nature of these services do not differ from personal care services furnished under the State Plan. The provider qualifications specified in the State Plan apply. Services purchased using 3.2 can supplement but not supplant IHSS. Personal care service providers may be paid while the waiver participant is institutionalized. This payment is made to retain the services of the care provider and is limited to seven (7) calendar days per institutionalization. Counseling & Therapeutic Services- Therapeutic Services (3.3): This service addresses unmet needs of waiver participants when such care is not otherwise available under the State Plan. These services will be provided based on the following criteria: The waiver participant assessment	not require medical skills and can be performed by an individual trained to summon aid in the event of an emergency. This service may also provide a visit to the waiver participant's home to assess a medical situation during an emergency (e.g., natural disaster).		

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
	identifies need for this support and the care plan reflects the required service(s). MSSP waiver participants are extremely frail and, on occasion, in need of services that cannot be provided under that cannot be provided under Medi-Cal. This MSSP service supplements but does not supplant benefits provided by the State Plan. Therapeutic Services includes the following: foot care, massage therapy, and swim therapy. Supplemental Protective Supervision (3.7): Ensures provision of supervision in the absence of the usual care provider to persons residing in their own homes, who are very frail or otherwise may suffer a medical emergency. Such supervision serves to prevent immediate placement in an acute care hospital, skilled nursing facility, or other 24-hour care facility. Such supervision does not require medical skills and can be performed by an individual trained to summon aid in the event of an emergency. This service may also provide a visit to the waiver participant's home to assess a medical			

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
	situation during an emergency (e.g., natural disaster). Waiver Service funds may not be used to purchase this service until existing county Title XX Social Services and Title XIX Medi-Cal resources have been fully utilized and an unmet need remains.			
Exhibit A, Article III.7	Services purchased using 3.7 can supplement but not supplant IHSS.	7. Therapeutic Services (3.3): This service addresses unmet needs of waiver participants when such care is not otherwise available under the State Plan. These services will be provided based on the following criteria: The waiver participant assessment identifies need for this support and the care plan reflects the required service(s). MSSP waiver participants are extremely frail and, on occasion, in need of services that cannot be provided under that cannot be provided under Medi-Cal. This MSSP service supplements but does not supplant benefits provided by the State Plan. The service is provided by authorized	New language providing clarity for Therapeutic Services, including EVV components	MSSP Program

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
		individuals when such care is prescribed or approved by a physician. Therapeutic Services includes the following: foot care, massage therapy, and swim therapy. Therapeutic services provided in the home shall be subject to EVV requirements required by Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C. 1396b). Vendor contracts for 3.3 services must contain language that addresses EVV requirements.		
Exhibit A, Article III.8.	Allowable services are: • Social services and legal/paralegal consultation to assist the individual with addressing critical incidents, public benefits, housing issues, and/or safety issues consultation • Legal and paralegal professionals' consultation • • Dietitian/Nutrition consultation • • Pharmacy consultation • • Vital sign monitoring	Allowable services are: • • Social services and legal/paralegal consultation to assist the individual with addressing critical incidents, public benefits, housing issues, and/or safety issues • • Dietitian/Nutrition consultation • • Pharmacy consultation • • Vital sign monitoring	Added language regarding freedom of choice	MSSP Program

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
		Each component of this waiver service is separately authorized, and the participant may exercise free choice of providers for each component. The participant may choose to receive consultative clinical services either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described in the Waiver.		
Exhibit A, Article III.9.a	New section	The participant may choose to receive care management services either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described in the Waiver.	Added language into Care Management about how services can be in person or via telehealth	MSSP Program
Exhibit A, Article III.9.b	b. Deinstitutional Care Management (DCM) (4.6): This service is used ONLY with individuals who are institutionalized. It allows care management and Waiver Services to begin up to one hundred eighty (180) days prior to an individual's discharge from	b. Deinstitutional Care Management (DCM) (4.6): This service is used ONLY with individuals who are institutionalized. It allows care management to begin up to one hundred eighty (180) days prior to an individual's discharge from an	Removal of "and Waiver Services" for clarity.	MSSP Program

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
	an institution. It may be used in two situations, as follows:	institution. It may be used in two situations, as follows:		
Exhibit A, Article III.9.b	In either situation, all services (monthly Administration and Care Management, plus any purchased services) provided during this period are combined into one unit of DCM and billed upon discharge. For those individuals who do not successfully transition to the Waiver, all services provided are combined into one unit of DCM and billed at the end of the month in which the decision is made to cease MSSP activity.	All care management services (monthly Administration and Care Management) provided during this period are combined into one unit of DCM and billed upon discharge.	Removing similar language for economy of words	MSSP Program
Exhibit A, Article III.10	Respite (5.1, 5.2): The State Plan does not provide for respite care. "Respite care services shall be subject to EVV requirements required by Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C. 1396b)." By definition, the purpose of respite care is to relieve the waiver participant's informal caregiver and thereby prevent breakdown in the informal support system. Respite	Respite (5.1, 5.2): The State Plan does not provide for respite care. By definition, the purpose of respite care is to relieve the waiver participant's informal caregiver and thereby prevent breakdown in the informal support system. Respite service will include the supervision and care of a waiver participant, while the family or other individuals who normally provide primary care take short-term	Removed language about EVV from the beginning of the section and added it to the end of the section. Additionally added clarity around respite use and waiver funds	MSSP Program

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
	service will include the supervision and care of a waiver participant, while the family or other individuals who normally provide primary care take short-term relief or respite which allows them to continue as caregivers. Respite may also be needed in order to cover emergencies and extended absences of the caregiver. As dictated by the waiver participant's circumstances, services will be provided In-Home (5.1) or Out-of-Home (5.2). through appropriate available resources such as board and care facilities, skilled nursing facilities, etc. Federal Financial Participation will not be claimed for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence. Individuals providing services in the waiver participant's residence shall be trained and experienced in homemaker services, personal care, or home health services, depending on the requirements in the waiver participant's plan of care.	relief or respite which allows them to continue as caregivers. Respite may also be needed in order to cover emergencies and extended absences of the caregiver. As dictated by the waiver participant's circumstances, services will be provided In-Home (5.1) or Out-of-Home (5.2). Waiver Services will not be used for respite services provided beyond thirty consecutive days, or for any combination of direct care and protective supervision that exceeds 24 hours of care per day. Waiver Service funds will not be used for the cost of room and board. Individuals providing services in the waiver participant's residence shall be trained and experienced in homemaker services, personal care, or home health services, depending on the requirements in the waiver participant's plan of care. Respite care services provided in the home shall be subject to EVV requirements required by Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C.	not being used for room and board cost.	

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
		1396b). Vendor contracts for 5.1 services must contain language that addresses EVV requirements.		
Exhibit A, Article III.11	private taxicabs where no form of public mass transit or paratransit is available or accessible; or private taxicabs when they are subsidized by public programs or local government to service frail older adults and handicapped (e.g., in California, some counties provide reduced fare vouchers for trips made via private taxicabs for frail older adults and handicapped).	private taxicabs and ride-sharing services (such as Uber or Lyft) where no form of public mass transit or paratransit is available or accessible; or when they are subsidized by public programs or local government to service frail older adults and handicapped (e.g., in California, some counties provide reduced fare vouchers for trips made via private taxicabs for frail older adults and handicapped).	Removed duplicate reference of taxi-cabs and included ride share apps	MSSP Program
Exhibit A, Article III.11	Escort services will be provided when necessary to assure the safe transport of the waiver participant. Escort services may be authorized for those waiver participants who cannot manage to travel alone and require assistance beyond what is normally offered by the transportation provider. This service will be provided by trained paraprofessionals or professionals, depending on the waiver participant's condition and care plan requirements.	Escort services may be authorized for those waiver participants who cannot manage to travel alone and require assistance beyond what is normally offered by the transportation provider.	Highlighted language was deleted. Service may be authorized.	MSSP Program

STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
CONTRACT SUMMARY OF CHANGES
CDA 9008 (NEW 6/16)

Program: CDA-MSSP
Contract Number: MS2526
Contract Term: Fiscal Year July 2025- June 2026

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
Exhibit A, Article V.12.	12. Nutritional Services (7.1, 7.2, and 7.3): These services may be provided daily but are not to constitute a full nutritional regimen (three (3) meals a day)	12. Nutritional Services (7.1, 7.2, and 7.3): These services may be provided daily but are not to constitute a full nutritional regimen (three (3) meals a day) [42 CFR 440.180 (b)].	Adding a statutory citation	MSSP Program
Exhibit A, Article III.12.	c. Oral Nutritional Supplements (ONS) (7.3): If oral nutritional supplements (ONS) are to be purchased using Waiver Service funds, the following actions must occur and be documented in the Participant record: • The Nurse Care Manager (NCM) must assess the waiver participant's nutritional needs and determine that an ONS is advisable.	c. Oral Nutritional Supplements (ONS) (7.3): As Medi-Cal may cover ONS, efforts must be made to obtain ONS through a Medi-Cal Treatment Authorization Request (TAR). The process must be documented in the monthly progress notes. If oral nutritional supplements (ONS) are to be purchased using Waiver Service funds, the following actions must occur and be documented in the Participant record: • The Nurse Care Manager (NCM) must conduct a nutritional screen to assess the waiver participant's nutritional needs and determine that an ONS is advisable.	Added clarity surrounding Medi-Cal covering ONS.	MSSP Program

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STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
CONTRACT SUMMARY OF CHANGES
CDA 9008 (NEW 6/16)

Program: CDA-MSSP
Contract Number: MS2526
Contract Term: Fiscal Year July 2025- June 2026

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
Exhibit A, Article III.12.		The participant may choose to receive counseling and therapeutic services (8.3, 8.4, and 8.5) either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described in the Waiver.	Added new language regarding participants choosing in person or telehealth counseling and therapeutic services	MSSP Program
Exhibit A, Article III.12.a	These services are often provided by volunteers or through Title III of the Older Americans Act; however, these services may not be available in a particular community and do, infrequently, require purchase. The Waiver will be used to purchase friendly visiting only if the service is unavailable in the community or is inadequate as provided under other public or private programs.	These services are often provided by volunteers or through Title III of the Older Americans Act; however, these services may not be available in a particular community and do, infrequently, require purchase. The Waiver Service funds will be used to purchase friendly visiting only if the service is unavailable in the community or is inadequate as provided under other public or private programs. Social Support services provided in the home shall be subject to EVV requirements required by Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C. 1396b). Vendor contracts for 8.3 services must contain	New language provides EVV guidelines. Additionally, Service Funds was clarified when referencing a purchase	MSSP Program

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Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
		language that addresses EVV requirements.		
Exhibit E, Article F	F. Contractors shall ensure all subcontractors comply with Electronic Visit Verification (EVV) requirements pursuant to federal and state law. Updated guidance may be obtained through DHCS, the state department overseeing EVV implementation.	F. Contractors shall ensure all subcontractors comply with Electronic Visit Verification (EVV) requirements pursuant to federal and state law. The Contractor will provide EVV program monitoring, subcontractor training, ongoing subcontractor technical support, assistance with subcontractor compliance enforcement, and perform follow-up. Contractor will incorporate EVV requirements as part of their respective agreements involving applicable MSSP subcontractors. Updated guidance may be obtained through DHCS, the state department overseeing EVV implementation.	New language introduced to provide EVV guidance/expectations	MSSP Program

STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
CONTRACT SUMMARY OF CHANGES
CDA 9008 (NEW 6/16)

Program: CDA-MSSP
Contract Number: MS2526
Contract Term: Fiscal Year July 2025- June 2026

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
Exhibit F	Exhibit F – DHCS HIPAA Addendum	Various; see new addendum provided by DHCS	DHCS Updated	MSSP Program
Exhibit D 20. Questioned Costs	"Questioned costs" means...in the circumstances. (2 CFR 200.84)	Questioned cost has the meaning given in paragraphs (1) through (3). (1) Questioned cost means an amount, expended or received from a Federal award, that in the auditor's judgment: (i) Is noncompliant or suspected noncompliant with Federal statutes, regulations, or the terms and conditions of the Federal award; (ii) At the time of the audit, lacked adequate documentation to support compliance; or (iii) Appeared unreasonable and did not reflect the actions a prudent person would take in the Circumstances. (2 CFR 200.1)	Updated language and reference in the 2 CFR 200	Jeremy Jackson
Exhibit D 21. Recoverable Costs	"Recoverable cost" means...from an audit. (2 CFR 200.1)	Remove CFR citation	CFR doesn't define recoverable cost.	Jeremy Jackson

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STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING

CONTRACT SUMMARY OF CHANGES

CDA 9008 (NEW 6/16)

Program: CDA-MSSP

Contract Number: MS2526

Contract Term: Fiscal Year July 2025- June 2026

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
Exhibit D Article X Audit Requirements (a)	Contractors that expend $750,000 or more...	Contractors that expend $1,000,000 or more	Updated amount in CFR	Jeremy Jackson
Exhibit D Article X Audit Requirements (b)	Any costs of auditing a non-federal...are less than $750,000 during the non-federal entity's fiscal year.	Change the $750K to $1M	Updated amount in CFR	Jeremy Jackson
Exhibit D, Article XII, F	Unless mutually agreed upon, the Contractor does not have the authority to terminate the Agreement.	Unless mutually agreed upon, the Contractor does not have the authority to determine the date of termination of the Agreement.	Added clarity surrounding the date of termination is what needs to be mutually agreed upon	MSSP Program via suggestion from Legal.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 4/14/2025

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Alliant Insurance Services, Inc.
560 Mission St 6th Fl
San Francisco CA 94105

License#: 0C36861

CONTACT NAME: Elizabeth Scarborough
PHONE (A/C, No, Ext): 415-855-8590 **FAX (A/C, No):**
E-MAIL ADDRESS: elizabeth.scarborough@alliant.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : National Fire Insurance Compan	20478
INSURER B : Continental Insurance Company	35289
INSURER C : American Casualty Company of R	20427
INSURER D : Syndicate 2623/623 at Lloyd's	
INSURER E : TDC National Assurance Company	41050
INSURER F : Allied World Surplus Lines Ins	24319

INSURED
Orange County Health Authority dba CalOptima
505 City Parkway West
Orange CA 92868

CALOHEA-01

COVERAGES **CERTIFICATE NUMBER:** 298627041 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
B	X **COMMERCIAL GENERAL LIABILITY** CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC OTHER:	Y		7063951685	4/7/2025	4/7/2026	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 100,000 $ 15,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
B	**AUTOMOBILE LIABILITY** X ANY AUTO OWNED AUTOS ONLY SCHEDULED AUTOS HIRED AUTOS ONLY X NON-OWNED AUTOS ONLY	Y		7063950620	4/7/2025	4/7/2026	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
B	X **UMBRELLA LIAB** X OCCUR **EXCESS LIAB** CLAIMS-MADE DED RETENTION $			7063953632	4/7/2025	4/7/2026	EACH OCCURRENCE AGGREGATE	$ 15,000,000 $ 15,000,000
A C	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N: N **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		7063950326 7063950648	4/7/2025 4/7/2025	4/7/2026 4/7/2026	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000
D E F	Cyber Liability E&O Med Care MedMal Liability			FN2517834 MCP-00174-25-06 0311-7585	4/7/2025 4/7/2025 4/7/2025	4/7/2026 4/7/2026 4/7/2026	Per Claim/Aggregate Limit Per Claim/Aggregate	$5,000,000 $10,000,000 $1M/$3M

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Coverage: 1st excess Cyber Liability, Policy #720000715-0003, Term: 04/07/2025 to 04/07/2026, Carrier: Homeland Insurance Company of New York, Limit: $10M xs $10M.

Re: MS-2526-41.
CA Department of Aging and MSSP are included as Additional Insured with respect to the General Liability and Auto Liability to the extent provided in the selected pages of the attached forms.

CERTIFICATE HOLDER

CA Department of Aging
1300 National Drive, Suite 200
Sacramento CA 95834

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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1. ADDITIONAL INSUREDS

a. **WHO IS AN INSURED** is amended to include as an **Insured** any person or organization described in paragraphs **A.** through **K.** below whom a **Named Insured** is required to add as an additional insured on this **Coverage Part** under a written contract or written agreement, provided such contract or agreement:

(1) is currently in effect or becomes effective during the term of this **Coverage Part**; and

(2) was executed prior to:

(a) the **bodily injury** or **property damage**; or

(b) the offense that caused the **personal and advertising injury**,

for which such additional insured seeks coverage.

b. However, subject always to the terms and conditions of this policy, including the limits of insurance, the Insurer will not provide such additional insured with:

(1) a higher limit of insurance than required by such contract or agreement; or

(2) coverage broader than required by such contract or agreement, and in no event broader than that described by the applicable paragraph **A.** through **K.** below.

Any coverage granted by this endorsement shall apply only to the extent permissible by law.

A. Controlling Interest

Any person or organization with a controlling interest in a **Named Insured**, but only with respect to such person or organization's liability for **bodily injury**, **property damage** or **personal and advertising injury** arising out of:

1. such person or organization's financial control of a **Named Insured**; or

2. premises such person or organization owns, maintains or controls while a **Named Insured** leases or occupies such premises;

provided that the coverage granted by this paragraph does not apply to structural alterations, new construction or demolition operations performed by, on behalf of, or for such additional insured.

B. Co-owner of Insured Premises

A co-owner of a premises co-owned by a **Named Insured** and covered under this insurance but only with respect to such co-owner's liability for **bodily injury**, **property damage** or **personal and advertising injury** as co-owner of such premises.

C. Grantor of Franchise

Any person or organization that has granted a franchise to a **Named Insured**, but only with respect to such person or organization's liability for **bodily injury**, **property damage** or **personal and advertising injury** as grantor of a franchise to the **Named Insured**.

D. Lessor of Equipment

Any person or organization from whom a **Named Insured** leases equipment, but only with respect to liability for **bodily injury**, **property damage** or **personal and advertising injury** caused, in whole or in part, by the **Named Insured's** maintenance, operation or use of such equipment, provided that the **occurrence** giving rise to such **bodily injury**, **property damage** or the offense giving rise to such **personal and advertising injury** takes place prior to the termination of such lease.

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E. Lessor of Land

Any person or organization from whom a **Named Insured** leases land but only with respect to liability for **bodily injury**, **property damage** or **personal and advertising injury** arising out of the ownership, maintenance or use of such land, provided that the **occurrence** giving rise to such **bodily injury**, **property damage** or the offense giving rise to such **personal and advertising injury** takes place prior to the termination of such lease. The coverage granted by this paragraph does not apply to structural alterations, new construction or demolition operations performed by, on behalf of, or for such additional insured.

F. Lessor of Premises

An owner or lessor of premises leased to the **Named Insured**, or such owner or lessor's real estate manager, but only with respect to liability for **bodily injury**, **property damage** or **personal and advertising injury** arising out of the ownership, maintenance or use of such part of the premises leased to the **Named Insured**, and provided that the **occurrence** giving rise to such **bodily injury** or **property damage**, or the offense giving rise to such **personal and advertising injury**, takes place prior to the termination of such lease. The coverage granted by this paragraph does not apply to structural alterations, new construction or demolition operations performed by, on behalf of, or for such additional insured.

G. Mortgagee, Assignee or Receiver

A mortgagee, assignee or receiver of premises but only with respect to such mortgagee, assignee or receiver's liability for **bodily injury**, **property damage** or **personal and advertising injury** arising out of the **Named Insured's** ownership, maintenance, or use of a premises by a **Named Insured**.

The coverage granted by this paragraph does not apply to structural alterations, new construction or demolition operations performed by, on behalf of, or for such additional insured.

H. State or Governmental Agency or Subdivision or Political Subdivisions – Permits

A state or governmental agency or subdivision or political subdivision that has issued a permit or authorization but only with respect to such state or governmental agency or subdivision or political subdivision's liability for **bodily injury**, **property damage** or **personal and advertising injury** arising out of:

1. the following hazards in connection with premises a **Named Insured** owns, rents, or controls and to which this insurance applies:

a. the existence, maintenance, repair, construction, erection, or removal of advertising signs, awnings, canopies, cellar entrances, coal holes, driveways, manholes, marquees, hoistaway openings, sidewalk vaults, street banners, or decorations and similar exposures; or

b. the construction, erection, or removal of elevators; or

c. the ownership, maintenance or use of any elevators covered by this insurance; or

2. the permitted or authorized operations performed by a **Named Insured** or on a **Named Insured's** behalf.

The coverage granted by this paragraph does not apply to:

a. **Bodily injury**, **property damage** or **personal and advertising injury** arising out of operations performed for the state or governmental agency or subdivision or political subdivision; or

b. **Bodily injury** or **property damage** included within the **products-completed operations hazard**.

With respect to this provision's requirement that additional insured status must be requested under a written contract or agreement, the Insurer will treat as a written contract any governmental permit that requires the **Named Insured** to add the governmental entity as an additional insured.

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I. Trade Show Event Lessor

1. With respect to a **Named Insured's** participation in a trade show event as an exhibitor, presenter or displayer, any person or organization whom the **Named Insured** is required to include as an additional insured, but only with respect to such person or organization's liability for **bodily injury**, **property damage** or **personal and advertising injury** caused by:

a. the **Named Insured's** acts or omissions; or

b. the acts or omissions of those acting on the **Named Insured's** behalf,

in the performance of the **Named Insured's** ongoing operations at the trade show event premises during the trade show event.

2. The coverage granted by this paragraph does not apply to **bodily injury** or **property damage** included within the **products-completed operations hazard**.

J. Vendor

Any person or organization but only with respect to such person or organization's liability for **bodily injury** or **property damage** arising out of **your products** which are distributed or sold in the regular course of such person or organization's business, provided that:

1. The coverage granted by this paragraph does not apply to:

a. **bodily injury** or **property damage** for which such person or organization is obligated to pay **damages** by reason of the assumption of liability in a contract or agreement unless such liability exists in the absence of the contract or agreement;

b. any express warranty unauthorized by the **Named Insured**;

c. any physical or chemical change in any product made intentionally by such person or organization;

d. repackaging, except when unpacked solely for the purpose of inspection, demonstration, testing, or the substitution of parts under instructions from the manufacturer, and then repackaged in the original container;

e. any failure to make any inspections, adjustments, tests or servicing that such person or organization has agreed to make or normally undertakes to make in the usual course of business, in connection with the distribution or sale of the products;

f. demonstration, installation, servicing or repair operations, except such operations performed at such person or organization's premises in connection with the sale of a product;

g. products which, after distribution or sale by the **Named Insured**, have been labeled or relabeled or used as a container, part or ingredient of any other thing or substance by or for such person or organization; or

h. **bodily injury** or **property damage** arising out of the sole negligence of such person or organization for its own acts or omissions or those of its employees or anyone else acting on its behalf. However, this exclusion does not apply to:

(1) the exceptions contained in Subparagraphs **d.** or **f.** above; or

(2) such inspections, adjustments, tests or servicing as such person or organization has agreed with the **Named Insured** to make or normally undertakes to make in the usual course of business, in connection with the distribution or sale of the products.

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2. This Paragraph **J.** does not apply to any insured person or organization, from whom the **Named Insured** has acquired such products, nor to any ingredient, part or container, entering into, accompanying or containing such products.

3. This Paragraph **J.** also does not apply:

a. to any vendor specifically scheduled as an additional insured by endorsement to this **Coverage Part**;

b. to any of **your products** for which coverage is excluded by endorsement to this **Coverage Part**; nor

c. if **bodily injury** or **property damage** included within the **products-completed operations hazard** is excluded by endorsement to this **Coverage Part**.

K. Other Person Or Organization

Any person or organization who is not an additional insured under Paragraphs **A.** through **J.** above. Such additional insured is an **Insured** solely for **bodily injury**, **property damage** or **personal and advertising injury** for which such additional insured is liable because of the **Named Insured's** acts or omissions.

The coverage granted by this paragraph does not apply to any person or organization:

1. for **bodily injury**, **property damage**, or **personal and advertising injury** arising out of the rendering or failure to render any professional service;

2. for **bodily injury** or **property damage** included within the **products-completed operations hazard**; nor

3. who is specifically scheduled as an additional insured on another endorsement to this **Coverage Part**.

2. ADDITIONAL INSURED - PRIMARY AND NON-CONTRIBUTORY TO ADDITIONAL INSURED'S INSURANCE

A. The **Other Insurance** Condition in the **COMMERCIAL GENERAL LIABILITY CONDITIONS** Section is amended to add the following paragraph:

If the **Named Insured** has agreed in writing in a contract or agreement that this insurance is primary and non-contributory relative to an additional insured's own insurance, then this insurance is primary, and the Insurer will not seek contribution from that other insurance. For the purpose of this Provision **2.**, the additional insured's own insurance means insurance on which the additional insured is a named insured.

B. With respect to persons or organizations that qualify as additional insureds pursuant to paragraph **1.K.** of this endorsement, the following sentence is added to the paragraph above:

Otherwise, and notwithstanding anything to the contrary elsewhere in this Condition, the insurance provided to such person or organization is excess of any other insurance available to such person or organization.

3. BODILY INJURY – EXPANDED DEFINITION

Under **DEFINITIONS**, the definition of **bodily injury** is deleted and replaced by the following:

Bodily injury means physical injury, sickness or disease sustained by a person, including death, humiliation, shock, mental anguish or mental injury sustained by that person at any time which results as a consequence of the physical injury, sickness or disease.

4. BROAD KNOWLEDGE OF OCCURRENCE/ NOTICE OF OCCURRENCE

Under **CONDITIONS**, the condition entitled **Duties in The Event of Occurrence, Offense, Claim or Suit** is amended to add the following provisions:

A. BROAD KNOWLEDGE OF OCCURRENCE

The **Named Insured** must give the Insurer or the Insurer's authorized representative notice of an **occurrence**, offense or **claim** only when the **occurrence**, offense or **claim** is known to a natural person **Named Insured**, to a

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partner, executive officer, manager or member of a **Named Insured**, or to an **employee** designated by any of the above to give such notice.

B. NOTICE OF OCCURRENCE

The **Named Insured's** rights under this **Coverage Part** will not be prejudiced if the **Named Insured** fails to give the Insurer notice of an **occurrence**, offense or **claim** and that failure is solely due to the **Named Insured's** reasonable belief that the **bodily injury** or **property damage** is not covered under this **Coverage Part**. However, the **Named Insured** shall give written notice of such **occurrence**, offense or **claim** to the Insurer as soon as the **Named Insured** is aware that this insurance may apply to such **occurrence**, offense or **claim**.

5. BROAD NAMED INSURED

WHO IS AN INSURED is amended to delete its Paragraph **3.** in its entirety and replace it with the following:

3. Pursuant to the limitations described in Paragraph **4.** below, any organization in which the **First Named Insured** has management control directly or indirectly:

a. on the effective date of this **Coverage Part**; or

b. by reason of a **Named Insured** creating or acquiring the organization during the **policy period**,

qualifies as a **Named Insured**, provided that there is no other similar liability insurance, whether primary, contributory, excess, contingent or otherwise, which provides coverage to such organization, or which would have provided coverage but for the exhaustion of its limit, and without regard to whether its coverage is broader or narrower than that provided by this insurance.

But this **BROAD NAMED INSURED** provision does not apply to any organization for which coverage is excluded by another endorsement attached to this **Coverage Part**.

For the purpose of this provision, and of this endorsement's **JOINT VENTURES / PARTNERSHIP / LIMITED LIABILITY COMPANIES** provision, management control means owning interests representing more than 50% of the voting, appointment or designation power for the selection of a majority of: the Board of Directors of a corporation; the management committee members of a joint venture; the management board of a limited liability company; the general partners of a limited partnership; or the partnership managers of a general partnership.

4. With respect to organizations which qualify as **Named Insureds** by virtue of Paragraph **3.** above, this insurance does not apply to:

a. **bodily injury** or **property damage** that first occurred prior to the date of management control, or that first occurs after management control ceases; nor

b. **personal or advertising injury** caused by an offense that first occurred prior to the date of management control or that first occurs after management control ceases.

5. The insurance provided by this **Coverage Part** applies to **Named Insureds** when trading under their own names or under such other trading names or doing-business-as names (dba) as any **Named Insured** should choose to employ.

6. ESTATES, LEGAL REPRESENTATIVES, AND SPOUSES

The estates, heirs, legal representatives and **spouses** of any natural person **Insured** shall also be insured under this policy; provided, however, coverage is afforded to such estates, heirs, legal representatives, and **spouses** only for **claims** arising solely out of their capacity or status as such and, in the case of a **spouse**, where such **claim** seeks **damages** from marital community property, jointly held property or property transferred from such natural person **Insured** to such **spouse**. No coverage is provided for any act, error or omission of an estate, heir, legal representative, or **spouse** outside the scope of such person's capacity or status as such, provided however that the **spouse** of a natural person **Named Insured** and the **spouses** of members or partners of joint venture or partnership

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ADDITIONAL INSURED - PRIMARY AND NON-CONTRIBUTORY

It is understood and agreed that this endorsement amends the **BUSINESS AUTO COVERAGE FORM** as follows:

SCHEDULE
Name of Additional Insured Person Or Organization
ANY PERSON OR ORGANIZATION THAT YOU ARE REQUIRED BY WRITTEN CONTRACT OR WRITTEN AGREEMENT TO NAME AS AN ADDITIONAL INSURED.

1. In conformance with paragraph **A.1.c.** of **Who Is An Insured** of Section **II** - LIABILITY COVERAGE, the person or organization scheduled above is an insured under this policy.
2. The insurance afforded to the additional insured under this policy will apply on a primary and non-contributory basis if you have committed it to be so in a written contract or written agreement executed prior to the date of the "**accident**" for which the additional insured seeks coverage under this policy.

All other terms and conditions of the policy remain unchanged

This endorsement, which forms a part of and is for attachment to the policy issued by the designated Insurers, takes effect on the Policy Effective date of said policy at the hour stated in said policy, unless another effective date (the Endorsement Effective Date) is shown below, and expires concurrently with said policy.

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ARTICLE I. MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP) OVERVIEW

The Multipurpose Senior Services Program (MSSP) is a Medi-Cal Home and Community Based Services (HCBS) Waiver, Control Number CA.0141.R07.00 authorized pursuant to Section 1915(c) of Title XIX of the Social Security Act. The primary objectives of the MSSP are to:

1. Avoid the premature placement of frail older persons in nursing facilities

2. Foster independent living in their communities

Pursuant to an Interagency Agreement between Department of Health Care Services (DHCS) and California Department of Aging (CDA), CDA contracts with local government entities and private nonprofit organizations for local administration of the MSSP throughout the State. The Contractor is responsible for arranging for and monitoring community services to the MSSP waiver participant population in the catchment area identified in Exhibit G of this Agreement. Individuals eligible for MSSP must be age sixty (60) or older; meet the eligibility criteria as a Medi-Cal recipient with an eligible Medi-Cal Aid Code be certifiable for placement in a nursing facility; live within a site's catchment area; be served within the program's cost limitations; and be deemed appropriate for care management services.

The Contractor uses a care management team to assess eligibility and need and provide for delivery of services. The Contractor is reimbursed for expenditures through a claims process operated by the State's Medi-Cal Fiscal Intermediary (see definition in Article VI of this Exhibit).

ARTICLE II. MSSP PROGRAM OPERATIONS

The Contractor shall be responsible for all care management obligations including processing waiver participant applications, predetermining eligibility, conducting assessments, developing care plans, case recording and documentation, and providing follow-up. The Contractor shall directly provide or arrange for the continuous availability and accessibility of all services identified in each waiver participant's care plan. The Contractor shall also ensure that the administrative integrity of the MSSP is maintained at all times. In order to maintain adequate administrative control, the Contractor shall incorporate the following components into the scope of operations:

A. Care Management Team

1. The Contractor shall maintain and have on file a written description and an organizational chart that outlines the structure of authority, responsibility, and accountability within the MSSP and the MSSP parent organization. The Contractor shall provide to its assigned CDA analyst a copy of the organization chart within thirty (30) days of the execution of this Agreement.

2. The Contractor shall employ a care management team, which consists of a social worker and a registered nurse, that meet the qualifications set forth in

ARTICLE II. MSSP PROGRAM OPERATIONS (Continued)

the Waiver. The care management team shall predetermine waiver participant eligibility based on the criteria specified in the MSSP Site Manual, herein incorporated by reference, then submit all required documentation to CDA for review. The final determination of eligibility will be made by CDA MSSP Bureau nurses, using assessment(s) and the Level of Care (LOC) form completed by the site care management team. This team shall work with the waiver participant throughout the care management process (e.g., assessment, care plan development, service coordination, and service delivery).

3. The care management team shall: 1) provide information, education, counseling, and advocacy to the waiver participant and family, and 2) identify resources to help assure the timely, effective, and efficient mobilization and allocation of all services, regardless of the source, to meet the waiver participant's care plan goals.

4. The Contractor shall annually self-certify that staff meet the requirements as outlined in the MSSP Site Manual as well as participate in required trainings.

B. Care Plan

1. The Contractor's care management team shall perform the MSSP waiver participant's assessments and work with the MSSP waiver participant, family, managed care plans, and others to develop a care plan covering the full range of required psychosocial and health services. The care management team shall continue to work with the MSSP waiver participant to assure that the waiver participant is receiving and benefiting from the services and to determine if modification of the care plan is required.

2. Such MSSP subcontracts shall specify terms and conditions and payment amount and shall assure that subcontractors shall not seek additional or outstanding unpaid amounts from the MSSP participant.

C. Purchased Waiver Services

"Purchased Waiver Services" means goods and services approved for purchase under Title XIX of the Social Security Act, 1915(c) Home and Community Based Waiver authority. The list of MSSP Purchased Waiver Services is included in Article VI. The Contractor may purchase MSSP Purchased Waiver Services when necessary to support the well-being of a MSSP waiver participant.

1. Prior to purchasing services, the Contractor shall verify, and document its efforts, that alternative resources are not available (e.g., family, friends and/or other community resources)

2. The Contractor may either enter into contracts with subcontractors to provide Purchased Waiver Services or directly purchase items through the use of a purchase order.

ARTICLE II. MSSP PROGRAM OPERATIONS (Continued)

3. The Contractor shall maintain written, signed and dated subcontracts for the following array of Purchased Waiver Services as defined in MSSP Site Manual at all times during the terms of this Agreement:

   a) Adult Day Care (ADC)
   b) Minor Home Repair/Maintenance Services
   c) Supplemental Homemaker, Personal Care and Protective Supervision Services
   d) Consultative Clinical Services
   e) Respite Care
   f) Transportation
   g) Meal Services
   h) Counseling and Therapeutic Services
   i) Communication Services

4. The Contractor shall assure that its subcontractors have the license(s), credentials, training, qualifications or experience to provide services to the MSSP participant.

5. The Contractor shall be responsible for coordinating and tracking MSSP Purchased Waiver Services for a MSSP waiver participant.

6. The Contractor shall operate a Multipurpose Senior Services Program at a location and in a manner approved by the State, ensuring that waiver participant inquiries and requests for service(s) receive prompt response.

D. Case Files

The Contractor shall maintain an up-to-date, centralized, and secured case file record for each waiver participant, consisting, at a minimum, of the following documents prescribed by CDA:

1. Application for the MSSP

2. MSSP Authorization for Use and Disclosure of Protected Health Information

3. Participant Enrollment/Termination Information

4. Finalized Level of Care (LOC) form that contains the approval signature of a CDA MSSP Bureau nurse, certifying certification by the Contractor that a MSSP Applicant or MSSP waiver participant meets the requirement(s) for nursing facility placement

5. MSSP Initial Health Assessment, MSSP Initial Psychosocial Assessment, and MSSP Reassessments

ARTICLE II. MSSP PROGRAM OPERATIONS (Continued)

6. Care Plan and Service Planning and Utilization Summary (SPUS)

7. Waiver Participant monthly progress notes and other waiver participant-related information (e.g., correspondence, medical/psychological/social records, service delivery verification)

8. Denial or discontinuance letters (Notice of Action)

9. Termination documents

10. Fair Hearing documentation

E. Management Information Systems (MIS)

The Contractor shall maintain and operate an MIS at its site. The Contractor shall:

1. Maintain office space with proper security and climate control for on-site computer hardware, e.g., terminals, processors, modems, and printers.

2. Provide adequate staff for timely, accurate, and complete MIS data input, including but not limited to:

   a. Waiver participant name, MSSP waiver participant number, Medi--Cal aid code, county code, Medicare and Social Security numbers, birth date, emergency contact information, physician information, and demographic information

   b. Tracking of Waiver Services and costs

   c. Enrollment and termination dates

   d. Provider Index Report

3. Accommodate State-required changes in MIS procedures which may be necessary from time to time.

4. Generate reports as required by the State.

5. Submit to CDA by the 5th working day of the month (unless otherwise specified by CDA), the active waiver participant count for the preceding month. The active waiver participant count consists of the number of waiver participants actively enrolled in MSSP on the last (business) day of the reporting month. This includes applicants with a LOC determination submitted to CDA pending approval but does not include waiver participant cases closed (or terminated) during the reporting month.

ARTICLE II. MSSP PROGRAM OPERATIONS (Continued)

6. Submit to CDA, by the 5th working day of the month (unless otherwise specified by CDA), the Wait List of participants as of the last day of the previous month. "Wait List" means a list of potential MSSP participants, established, and maintained by the Contractor, when the Contractor has reached its capacity. To ensure compliance with MSSP Waiver requirements and Centers for Medicare and Medicaid Services (CMS) direction, MSSP sites must develop and implement a wait list policy and procedure. The policy and procedure must include provisions for: prescreening individuals to predetermine eligibility; managing applicants' placement on and removal from the wait list; periodically reviewing the eligibility and identified needs of applicants on the wait list; and assigning priority for enrollment based on identified needs and level of risk. The Contractor determines the priority of enrollment into the MSSP in accordance with CDA and CMS requirements.

7. Verify all service data within ninety (90) calendar days of the date of service. The Contractor shall submit this data to CDA by the 5th calendar day of the following month, ninety-five (95) days from the end of the month of services.

8. Submit claims to the State's Medi-Cal Fiscal Intermediary (FI), per instructions stated in the Medi-Cal Provider Manual.

F. Enrollment Levels

The Contractor shall maintain a caseload of no less than 95 percent and no more than 105 percent of the specified number of participant slots for the term of contract (12 months). This is a performance requirement to ensure compliance with the terms and conditions of this Agreement and Waiver requirements. If the Contractor's active participant count falls below ninety-five percent (95%) of the number of budgeted participant slots for more than three (3) consecutive months, the Contractor shall be required to submit a Corrective Action Plan for review, approval, and monitoring by CDA.

"Participant slot" means a position, whether vacant or filled, which is funded according to a Contractor's site budget and allocated for a participant during a given month.

1. Voluntarily Relinquishing Slots

   a. At any time and for any reason, a Contractor may voluntarily request to return slots in increments of 10, preferably 40.

   b. A Contractor may initiate the slot relinquishment process by notifying CDA in writing.

2. Request for Additional Slots

ARTICLE II. MSSP PROGRAM OPERATIONS (Continued)

a. A Contractor operating at 95% enrollment or higher may submit a written request for additional slots. The Contractor can request slots in increments of 40. CDA will notify the Contractor of its determination within 60 days.

G. Emergency Preparedness

1. The Contractor shall prepare and implement an emergency preparedness plan that ensures the provision of services to meet the emergency needs of waiver participants they are charged to serve during medical or natural disasters: a pandemic, earthquake, fire, flood, or public emergencies, such as riot, energy shortage, hazardous material spill, etc. This plan shall conform to any statewide requirements issued by any applicable State or local authority.

2. The Contractor shall adopt policies and procedures that address emergency situations and ensure that there are safeguards in place to protect and support waiver participants in the event of natural disasters or other public emergencies.

3. The Contractor shall ensure that emergency preparedness policies and procedures are clearly communicated to site staff and subcontractors in order to provide care under emergency conditions and to provide for back-up in the event that usual care is unavailable.

4. The Contractor shall develop an emergency preparedness training plan to be provided to all staff at least annually and as needed when new staff are hired. The training shall consist of:

   a. Familiarity with telephone numbers of fire, police, and ambulance services for the geographic area served by the provider

   b. Techniques to obtain vital information from older individuals who require emergency assistance

   c. Written emergency procedures for all staff that have contact with older individuals

5. The Contractor shall develop a method for documenting the emergency preparedness training provided for all staff.

6. The Contractor shall develop a program for testing its emergency preparedness plan at least annually.

H. Other Provisions

1. The Contractor is relieved of all obligations to arrange for and provide services to a waiver participant under this Agreement after the waiver participant has been terminated from the MSSP and has exhausted their appeal rights.

ARTICLE II. MSSP PROGRAM OPERATIONS (Continued)

2. The Contractor shall provide a notice of termination to a waiver participant prior to terminating the participant from the MSSP and shall reference the MSSP Site Manual to determine how many days' notice are required based on the type of termination code that is used.

3. The Contractor shall administer a subcontractor appeal and adjudication process. The subcontractor appeal and adjudication process must be included in all subcontracts. This process shall assure fair consideration and disposition of subcontractor claims against the Contractor. Final authority to decide claims shall be vested with the Contractor. The subcontractor has no right of appeal to CDA.

4. The Contractor shall serve participants in the Catchment Area as defined in Exhibit G of this Agreement. Any revisions to Exhibit G require CDA approval.

5. The Contractor shall abide by the MSSP Site Manual, training manuals, and other guidance issued by the CDA MSSP Bureau. The Contractor shall comply with any and all changes to State and federal law. The Contractor shall include this requirement in each of its subcontracts.

6. The Contractor shall make staff available to CDA for training and meetings which CDA may find necessary from time to time.

ARTICLE III. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER

Services Provided Under the Waiver – Contractors must have the ability to provide the following services to MSSP waiver participants:

Definitions of each of the services approved by the Centers for Medicare and Medicaid Services of the Department of Health and Human Services under the existing 1915(c) Home and Community-Based Services Waiver are as follows. The numbers in parentheses are program code designations for the particular service.

1. **Adult Day Care** (1.1): Will be provided when the waiver participant's plan of care indicates that the service is necessary to reach a therapeutic goal or provide respite for the family or caregiver. Adult day care centers are community-based programs that provide nonmedical care to persons eighteen (18) years of age or older in need of personal care services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of the individual on less than a 24-hour basis. The Department of Social Services (DSS) licenses these centers as community care facilities.

   Adult Day Care centers are subject to Federal Home and Community-Based Settings (HCBS) requirements, meaning they must:
   - Support access to the greater community;
   - Be selected by the participant from among setting options;

ARTICLE III. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (continued)

- Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimize autonomy and independence in making life choices;
- Facilitate choice regarding services and who provides them; and
- Be physically accessible.

Vendor contracts with Adult Day Care centers must contain language that addresses Home and Community-Based Settings requirements as specified in 42 CFR 441.301(c)(4).

2. **Minor Home Repairs and Maintenance** (2.2): Minor Home Repairs do not involve structural changes or major repairs to a dwelling. Maintenance is defined as those services necessary for accessibility (e.g., ramps, grab bars, handrails, items above what is covered by the State Plan, and installation), safety (e.g., electrical wiring, smoke alarms), or security (e.g., locks). Eligible waiver participants are those whose health and/or safety or independence are jeopardized because of deficiencies in their place of residence. This service is limited to waiver participants who are owners/occupiers of their own home, or those in rental housing where the owner refuses to make needed repairs or otherwise alter the residence to adapt to special waiver participant needs. Written permission from the landlord (including provision for removal of modifications, if necessary) is required before undertaking repairs or maintenance on leased premises. All services shall be provided in accordance with applicable State or local building codes.

3. **Specialized Non-medical Home Equipment** (2.3): Includes equipment and supplies which address a waiver participant's functional limitation and/or condition, are necessary to assure the waiver participant's health, safety, and independence, and are not otherwise provided through this Waiver or through the State Plan.

Allowable items:

- Small appliances
- Large appliances
- Furniture
- Home safety devices
- Clothing related items (Must stem from a medical or functional need)
- Paperwork related/ Organizing items
- Household items (Items that are not specifically designed for home safety, but are necessary to maintain independence and safety in the home)
- Kitchenware
- Bedding/Bath items
- Exercise equipment
- Social support/ Therapeutic activity supplies

ARTICLE III. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (continued)

- Personal care items (Items related to personal care and the prevention of skin breakdown)
- Health related supplies (Items that have a health component, but are not covered by the State Plan)
- Incontinence supplies (gloves, wipes, washcloths, and creams)

Experimental or prohibited treatments are excluded as well as those items and services solely for entertainment or recreation. The costs associated with delivery and repairs of the items allowable under this service are also included.

4. **Community Transition Services-** (2.4): These services allow for non-recurring moving and/or housing set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community. Eligible waiver participants are those who reside in a facility/institution or care provider-owned residence and are transitioning from a facility/institution to their own home or apartment in the community where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the waiver participant's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving services, which may include materials and necessary labor; (f) activities to assess need, arrange for and procure need resources. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the care plan development process, clearly identified in the care plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

5. **Assistive Technology** (2.6): Assistive technology means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a waiver participant in the selection, acquisition, or use of an assistive technology device. Assistive Technology includes: (A) the evaluation of the assistive technology needs of a waiver participant, which is performed and billed under the MSSP care management service. The evaluation includes a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the waiver participant; (B) services consisting of purchasing,

leasing, or otherwise providing for the acquisition of assistive technology devices for participants; applying, maintaining, repairing, or replacing assistive technology devices; (C) services consisting of selecting, designing, fitting, customizing, adapting; (D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the care plan. The costs associated with delivery and repairs of the items allowable under this service are also included.

Examples include, but are not limited to, a transfer pole, grabber/reacher, dressing aid or sock aid, etc.

6. **Supplemental Services (3.1, 3.2, and 3.7):** These services are for purposes of household support, personal care, and protective supervision for those services above and beyond those available through the In-Home Supportive Services (IHSS) Program or to participants that are not eligible for IHSS.

   Examples include:

   1. The MSSP participant has not yet been assessed for IHSS and needs services in the interim until IHSS can be arranged.

   2. The regular IHSS provider is not available and IHSS cannot provide a substitute.

   3. IHSS services are in place; however, MSSP has assessed a greater need. In these cases, MSSP will advocate with IHSS for increased time for those services before authorizing expenditure of Waiver funds.

   Services purchased can supplement but not supplant IHSS.

   Supplemental Homemaker, Personal Care, and Protective Supervision services shall be subject to Electronic Visit Verification (EVV) requirements required by Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C. 1396b). Vendor contracts for 3.1, 3.2, and 3.7 services must contain language that addresses EVV requirements.

   a) **Supplemental Homemaker Services** (3.1): are for purposes of household support and applies to the performance of household tasks rather than to the care of the waiver participant. Homemaker activities are limited to: household cleaning, laundry (including the services of a commercial laundry or dry cleaner), shopping, food preparation, and household maintenance. Instruction in performing household tasks may also be provided.

   b) **Supplemental Personal Care** (3.2): This service provides assistance to maintain bodily hygiene, personal safety, and activities of daily living (ADL).

ARTICLE III. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (continued)

c) These tasks are limited to nonmedical personal services: feeding, bathing, oral hygiene, grooming, dressing, care of and assistance with prosthetic devices, rubbing skin to promote circulation, turning in bed and other types of repositioning, assisting the individual with walking, and moving the individual from place to place (e.g., transferring). waiver participant instruction in self-care may also be provided.

d) **Supplemental Protective Supervision** (3.7): Ensures provision of supervision in the absence of the usual care provider to persons residing in their own homes, who are very frail or otherwise may suffer a medical emergency. Such supervision serves to prevent immediate placement in an acute care hospital, skilled nursing facility, or other 24-hour care facility. Such supervision does not require medical skills and can be performed by an individual trained to summon aid in the event of an emergency. This service may also provide a visit to the waiver participant's home to assess a medical situation during an emergency (e.g., natural disaster).

Waiver Participants that receive Supplemental Protective Supervision may also receive a room monitor under Communication: Device (9.2); however, are not allowed to also receive Emergency Response System (ERS) services.

7. **Therapeutic Services** (3.3): This service addresses unmet needs of waiver participants when such care is not otherwise available under the State Plan. These services will be provided based on the following criteria: The waiver participant assessment identifies need for this support and the care plan reflects the required service(s). MSSP waiver participants are extremely frail and, on occasion, in need of services that cannot be provided under that cannot be provided under Medi-Cal. This MSSP service supplements but does not supplant benefits provided by the State Plan. The service is provided by authorized individuals when such care is prescribed or approved by a physician. Therapeutic Services includes the following: foot care, massage therapy, and swim therapy.

Therapeutic services provided in the home shall be subject to EVV requirements required by Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C. 1396b). Vendor contracts for 3.3 services must contain language that addresses EVV requirements.

8. **Consultative Clinical Services** (4.3): This service addresses the unmet needs of waiver participants when such care is not otherwise available under the State Plan. These services will be provided based on the following criteria:

- The waiver participant assessment identifies need for this support and the care plan reflects the required service(s).

ARTICLE III. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (continued)

- MSSP utilizes all of the services available under the State Plan prior to purchasing these services as Waiver Services. MSSP's waiver participants are extremely frail and, on occasion, in need of services that cannot be provided under Medi-Cal. This service is especially critical for persons recently discharged from acute hospitals or who are otherwise recovering at home from an acute illness or injury. This MSSP service supplements, but does not supplant, benefits provided by the State Plan.

In addition to the provision of care, waiver participants and their families/caregivers are trained in techniques which will enable them (or their caregivers) to carry out their own care whenever possible.

Allowable services are:

- Social services and legal/paralegal consultation to assist the individual with addressing critical incidents, public benefits, housing issues, and/or safety issues
- Dietitian/Nutrition consultation
- Pharmacy consultation
- Vital sign monitoring

Each component of this waiver service is separately authorized and the participant may exercise free choice of providers for each component. The participant may choose to receive consultative clinical services either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described in the Waiver.

9. **Care Management**: Assists waiver participants in gaining access to needed Waiver and other State Plan services, as well as needed medical, social, and other services, regardless of the funding source. Care managers are responsible for ongoing monitoring of the provision of services included in the waiver participant's plan of care.

   a) **Care Management** (50): The MSSP care management system vests responsibility for assessing, care planning, authorizing, locating, coordinating, and monitoring a package of long-term care services for community-based waiver participants with a local MSSP site contractor and specifically with the site care management team. The care management teams at each of the local sites are trained professionals working under the job titles of Nurse Care Manager and Social Work Care Manager; these professionals may be assisted by Care Manager Aides. The teams are responsible for Care Management services including the assessment, care plan development, service authorization/delivery, monitoring, and follow-up components of the program. Case records must document all waiver participant contact activity each month.

ARTICLE III. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (continued)

The participant may choose to receive care management services either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described in the Waiver.

b) **Deinstitutional Care Management (DCM)** (4.6): This service is used ONLY with individuals who are institutionalized. It allows care management to begin up to one hundred eighty (180) days prior to an individual's discharge from an institution. It may be used in two situations, as follows:

- Where MSSP has gone into a facility (nursing facility or acute hospital) to begin working with a resident to facilitate their discharge into the community
- Where an established MSSP waiver participant is institutionalized and MSSP services are necessary for the person to be discharged back into the community

All care management services (monthly Administration and Care Management) provided during this period are combined into one unit of DCM and billed upon discharge. For those individuals who do not successfully transition to the Waiver, billing is disallowed, as Federal Financial Participation (FFP) cannot be claimed for DCM services where the participant does not transition into the Waiver. No care management services available under the State Plan will be duplicated under the MSSP Waiver.

10. **Respite** (5.1, 5.2): The State Plan does not provide for respite care. By definition, the purpose of respite care is to relieve the waiver participant's informal caregiver and thereby prevent breakdown in the informal support system. Respite service will include the supervision and care of a waiver participant, while the family or other individuals who normally provide primary care take short-term relief or respite which allows them to continue as caregivers. Respite may also be needed in order to cover emergencies and extended absences of the caregiver. As dictated by the waiver participant's circumstances, services will be provided In-Home (5.1) or Out-of-Home (5.2). Waiver Services will not be used for respite services provided beyond thirty consecutive days, or for any combination of direct care and protective supervision that exceeds 24 hours of care per day. Waiver Service funds will not be used for the cost of room and board. Individuals providing services in the waiver participant's residence shall be trained and experienced in homemaker services, personal care, or home health services, depending on the requirements in the waiver participant's plan of care.

Respite care services provided in the home shall be subject to EVV requirements required by Subsection (l) of Section 1903 of the Social Security

ARTICLE III. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (continued)

Act (SSA) (42 U.S.C. 1396b). Vendor contracts for 5.1 services must contain language that addresses EVV requirements.

11. **Transportation** (6.3 and 6.4): These services provide access to the community (e.g., non-emergency medical transportation to health and social service providers) and special events for waiver participants who do not have means for transportation or whose mobility is limited, or who have functional disabilities requiring specialized vehicles and/or escort. These services are in contrast to the transportation service authorized by the State Plan which is limited to medical services, or waiver participants who have documentation from their physician that they are medically unable to use public or ordinary transportation. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

    Transportation services are usually provided under public paratransit or public social service programs (e.g., Title III of the Older Americans Act) and shall be obtained through these sources without the use of MSSP resources, except in situations where such services are unavailable or inadequate. Service providers may be paratransit subsystems or public mass transit; specialized transport for the older adults and adults with disabilities; private taxicabs and ride-sharing services (such as Uber or Lyft) where no form of public mass transit or paratransit is available or accessible; or when they are subsidized by public programs or local government to service frail older adults and handicapped (e.g., in California, some counties provide reduced fare vouchers for trips made via private taxicabs for frail older adults and handicapped).

    Escort services may be authorized for those waiver participants who cannot manage to travel alone and require assistance beyond what is normally offered by the transportation provider.

12. **Nutritional Services** (7.1, 7.2, and 7.3): These services may be provided daily but are not to constitute a full nutritional regimen (three (3) meals a day) [42 CFR 440.180 (b)].

    a) **Congregate Meals** (7.1): Meals served in congregate meal settings for waiver participants who are able to leave their homes or require the social stimulation of a group environment in order to maintain a balanced diet. Congregate meals can be a preventive measure for the frail older person who has few (if any) informal supports, as well as a rehabilitative activity for people who have been physically ill or have suffered emotional stress due to losses associated with aging. This service should be available to MSSP waiver participants through Title III of the Older Americans Act. MSSP funds shall only be used to supplement congregate meals when funding is unavailable or inadequate through Title III or other public or private sources.

ARTICLE III. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (continued)

Congregate Meal Sites are subject to Federal Home and Community-Based Settings (HCBS) requirements, meaning they must:

- Support access to the greater community;
- Be selected by the participant from among setting options;
- Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimize autonomy and independence in making life choices;
- Facilitate choice regarding services and who provides them; and
- Be physically accessible.

Vendor contracts with Congregate Meal Sites must contain language that addresses Home and Community-Based Settings requirements as specified in 42 CFR 441.301(c)(4).

b) Home Delivered Meals (7.2): Meals for waiver participants who are homebound, unable to prepare their own meals and have no caregiver at home to prepare meals for them. As with Congregate Meals, the primary provider of this service is Title III of the Older Americans Act. MSSP funds shall only be used to supplement home-delivered meals when they are unavailable or inadequate through Title III or other public or private sources.

c) Oral Nutritional Supplements (ONS) (7.3): As Medi-Cal may cover ONS, efforts must be made to obtain ONS through a Medi-Cal Treatment Authorization Request (TAR). The process must be documented in the monthly progress notes. If oral nutritional supplements (ONS) are to be purchased using Waiver Service funds, the following actions must occur and be documented in the Participant record:

- The Nurse Care Manager (NCM) must conduct a nutritional screen to assess the waiver participant's nutritional needs and determine that an ONS is advisable.
- The use of home-prepared drinks/supplements (instant breakfast, pureed food) has been explored and found not to meet the Participant's needs.
- All other options for payment of an ONS have been exhausted (Waiver Participant, family, etc.).

If all three criteria have been satisfied, an ONS may be purchased initially for a period of three (3) months. If an ONS needs to be continued beyond the three-month timeframe, a physician order must be obtained. Upon annual reassessment, if all criteria, including a new nutritional screen, are satisfied and the previous physician order has expired, another three months may be purchased. The physician's order must be renewed on an annual basis.

ARTICLE III. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (continued)

13. **Counseling & Therapeutic Services** (8.3, 8.4, and 8.5): These services include protection for waiver participants who are isolated and homebound due to health conditions; who suffer from depression and other psychological problems; individuals who have been harmed or threatened with harm (physical or mental) by other persons or by their own actions; or those whose cognitive functioning is impaired to the extent they require assistance and support in

making and carrying out decisions regarding personal finances.

The participant may choose to receive counseling and therapeutic services (8.3, 8.4, and 8.5) either via telehealth or in-person. When provided via telehealth, the service must be provided in accordance with the telehealth assurances described in the Waiver.

a) **Social Support (8.3):** Includes periodic telephone contact, visiting, or other social and reassurance services to verify that the individual is not in medical, psychological, or social crisis, or to offset isolation. Such services shall be provided based on need, as designated in the waiver participant's plan of care. The MSSP has found that isolation and lack of social interaction can seriously impact some waiver participants' capacity to remain independent. Lack of motivation or incentive or the lack of any meaningful relationships can contribute to diminishing functional capacity and premature institutionalization.

These services are often provided by volunteers or through Title III of the Older Americans Act; however, these services may not be available in a particular community and do, infrequently, require purchase. Waiver Service funds will be used to purchase friendly visiting only if the service is unavailable in the community or is inadequate as provided under other public or private programs.

Social Support services provided in the home shall be subject to EVV requirements required by Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C. 1396b). Vendor contracts for 8.3 services must contain language that addresses EVV requirements.

b) **Therapeutic Counseling (8.4):** Includes individual or group counseling to assist with social, psychological, or medical problems which have been identified in the assessment process and included in the waiver participant's care plan. The MSSP has found that therapeutic counseling is essential for preventing some waiver participants from being placed in a nursing facility. This service may be utilized in situations where waiver participants or their caretakers may face crises, severe anxiety, emotional exhaustion, personal loss/grief, confusion, and related problems. Counseling by licensed or certified counselors in conjunction with other services (e.g., respite, IHSS, meals) may reverse some states of confusion and greatly enhance the ability of a family to

care for the waiver participant in the community or allow the waiver participant to cope with increasing impairment or loss.

c) **Money Management (8.5):** This service assists the waiver participant with activities related to managing money and the effective handling of personal finances. Services may be either periodic or as full-time substitute payee. Services may be provided by organizations or individuals specializing in financial management or performing substitute payee functions.

14. **Communication (9.1 and 9.2)**: waiver participants who receive these services are those with special communication problems such as vision, hearing, or speech impairments and persons with physical impairments likely to result in a medical emergency. Services shall be provided by organizations such as: speech and hearing clinics; organizations serving blind individuals; hospitals; senior citizens centers; and providers specializing in communications equipment for disabled or at-risk persons. Services shall be available on a routine or emergency basis as designated in the waiver participant's plan of care.

a. **Translation** (9.1): The provision of translation and interpretive services for purposes of instruction, linkage with social or medical services, and conduct of business is essential to maintaining independence and carrying out the ADL and Instrumental Activities of Daily Living (IADL) functions.

For non-English speaking waiver participants, this service is the link to the entire in-home and community-based service delivery system. MSSP resources shall be used to support this service only where family and community resources are unable to meet the need, and as described in the care plan.

b. **Device** (9.2): The rental/purchase of 24-hour emergency assistive services, or installation of a telephone to assist in communication (excluding monthly telephone charges) for waiver participants who are at risk of institutionalization due to physical conditions likely to result in a medical emergency. Purchase of Emergency Response Systems (ERS) is limited to those waiver participants who live alone, or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. The following are allowable:

1. 24-hour answering/paging
2. Medic-alert type bracelets/pendants
3. Intercoms
4. Emergency Response System
5. Room/two-way monitors

ARTICLE III. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (continued)

6. Light fixture adaptations (blinking lights, etc.)
7. Telephone adaptive devices not available from the telephone company

This service is limited to additional services and items not otherwise covered under the State Plan but are consistent with Waiver objectives of avoiding institutionalization. Telephone installation or reactivation of service will only be authorized to enable the use of telephone-based electronic response systems where the waiver participant has no telephone, or for the isolated waiver participant who has no telephone and who resides where the telephone is the only means of communicating health needs. This service will only be authorized when the waiver participant has a medical/health condition that makes him/her vulnerable to medical emergency.

Waiver participants that receive Supplemental Protective Supervision may also receive a room monitor under Communication: Device; however, are not allowed to also receive ERS services. These types of devices are intended to assist in keeping at-risk waiver participants safe in the home and are not intended to replace an in-person support staff.

ARTICLE IV. ELECTRONIC VISIT VERIFICATION (EVV)

1. Electronic Visit Verification (EVV) is a telephone and computer-based solution validating that in-home service visits occur. EVV solutions shall verify the: a) type of service performed; b) individual receiving the service; c) date of the service; d) location of service delivery; e) individual providing the services; and f) time the service begins and ends.

2. Pursuant to Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C. 1396b), Contractor shall implement DHCS-approved EVV solutions for Medicaid-funded personal care services and home health care services. Contractor and subcontractors shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 to prevent use or disclosure of the information as provided for by this Agreement.

ARTICLE I. INVOICING AND PAYMENT

A. To receive payment under the fee-for-service (FFS) payment model, the Contractor shall prepare and submit electronic claims through the State's Fiscal Intermediary (FI) as set forth in the Medi-Cal Provider Manual.

B. Payments shall be made in accordance with the following provisions:

1. The Contractor shall submit claims to Medi-Cal FI, based upon the month of service and only for actual expenses. On each claim, the Contractor shall show the amount billed for each service code.

2. Failure to provide data and reports specified by this Agreement will result in the delay of payment of invoices.

C. Payment will be made in accordance with, and within the time specified in, California Government Code, Chapter 4.5, commencing with Section 927.

D. Reimbursement for Performance

The Contractor shall be entitled to monthly payment for actual services delivered to the Contractor's monthly active participants. This amount may vary from month to month but total annual payments to the Contractor shall not exceed the amount of the Contractor's total participant slot budget for the year.

E. Rate Adjustment

Any rate adjustments must be submitted to CDA for approval. The rate change request should be submitted to MSSPService@aging.ca.gov and include the following information in their rate change request:

- Billing Code
- Effective Date
- Current Rate
- Requested Rate

F. Advance Payments

1. CDA may authorize an advance payment during the term of the Agreement pursuant to the Welfare and Institutions Code Section 9566 for Contractors providing services under the FFS payment model. Upon approval of this Agreement, the Contractor may request an advance not to exceed twenty-five percent (25%) of the total contract amount.

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ARTICLE I. INVOICING AND PAYMENT (continued)

2. A request for an advance payment shall be on the Contractor's letterhead and include both an original signature of authorized designee and the Agreement number. Requests for advances will not be accepted after the first day of that fiscal year unless otherwise authorized by CDA.

3. Any funds advanced under this Agreement, plus interest earned on same, shall be deducted from amounts due the Contractor. If, after settlement of the Contractor's final claim, the California Department of Health Care Services (DHCS) or CDA determines an amount is owed DHCS or CDA hereunder, DHCS or CDA shall notify the Contractor and the Contractor shall refund the requested amount within ten (10) working days of the date of the State's request.

4. The Contractor may at any time repay all or any part of the funds advanced hereunder. Whenever either party gives prior written notice of termination of this Agreement, the Contractor shall repay to DHCS, within ten (10) working days of such notice, the unliquidated balance of the advance payment.

5. Repayment of advances will be recovered from claims submitted to the State's FI after January 1st of each fiscal year and be collected at fifty percent (50%) of each claim submitted until the amount advanced is repaid. The Contractor may at any time be required to repay to DHCS all or any part of the advance.

6. Repayment of any remaining advance funds not collected through the process described in subsection 6 above, will be recovered through the Audit process.

ARTICLE II. FUNDS

A. Expenditure of Funds

1. The Contractor shall expend all funds received hereunder in accordance with this Agreement.

2. Any reimbursement for authorized travel and per diem shall be at rates not to exceed those amounts paid by the State in accordance with the California Department of Human Resources' (CalHR) rules and regulations.

ARTICLE II. FUNDS (Continued)

In State:

- Mileage/Per Diem (meals and incidentals)/Lodging

Out of State:

- Travel and Relocation Policy-Human Resource Manual

This is not to be construed as limiting the Contractor from paying any differences in costs, from funds other than those provided by CDA, between the CalHR rates and any rates the Contractor is obligated to pay under other contractual agreements. No travel outside the State of California shall be reimbursed unless prior written authorization is obtained from the State. [2 CCR 599.615 et seq.]

The Contractor agrees to include these requirements in all contracts it enters into with subcontractors/vendors to provide services pursuant to this Agreement.

3. DHCS and CDA reserve the right to refuse payment to the Contractor or later disallow costs for any expenditure as determined by DHCS or CDA to be out of compliance with this Agreement; unrelated or inappropriate to contract activities; when adequate supporting documentation is not presented; or where prior approval was required but was either not requested or granted.

4. The Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this Contract, shall 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 Contract.

5. CDA may require prior approval and may control the location, cost, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar workshop or conference conducted by the Contractor in relation to the program funded through this Contract. CDA may also maintain control over any reimbursable publicity, or education materials to be made available for distribution. The Contractor is required to acknowledge the support of CDA in writing, whenever publicizing the work under this Agreement in any media.

ARTICLE II. FUNDS (Continued)

6. Any overpayment of funds must be deposited into an interest-bearing account.

B. The Contractor shall maintain accounting records for funds received under the terms and conditions of this Agreement. These records shall be separate from those for any other funds administered by the Contractor and shall be maintained in accordance with Generally Accepted Accounting Principles and Procedures and Office of Management and Budget's– Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. [2 CFR Part 200]

C. Upon termination, cancellation, or expiration of this Agreement or dissolution of the entity, the Contractor, upon written demand, shall immediately return to DHCS any funds provided under this Agreement, which are not payable for goods or services delivered prior to the termination, cancellation, or expiration of this Agreement or the dissolution of the entity.

D. Interest Earned

1. Interest earned on federal advance payments deposited in interest bearing accounts must be remitted annually to the Department of Health and Human Services, Payment Management System, Rockville, MD 20852. Interest amounts up to $500 per year may be retained by the non Federal entity for administrative expense. [2 CFR § 200.305(b)(9)]

2. The Contractor must maintain advance payments of Federal awards in interest bearing accounts, unless the following apply.

   a. The Contractor receives less than $120,000 in Federal awards per year.

   b. The best reasonably available interest-bearing account would not be expected to earn interest in excess of $500 per year on federal cash balances.

   c. The depository would require an average or minimum balance so high that it would not be feasible within the expected federal and non-federal cash resources.

   d. A foreign government or banking system prohibits or precludes interest bearing accounts.

ARTICLE III. BUDGET AND BUDGET REVISION

Payment for performance by the Contractor under this contract may be dependent upon the availability of future appropriations by the Legislature or Congress for the purposes of this contract. No legal liability on the part of the State for any payment may arise under this contract until funds are made available and until the Contractor has received notice of funding availability, which will be confirmed in writing.

A. Funding Reduction in Subsequent Fiscal Years

1. If funding for any State fiscal year is reduced or eliminated by the Legislature, Congress, or Executive Branch of State Government for the purposes of this program, the State shall have the option to either:

   a. Terminate the Contract pursuant to Exhibit D, Article XII
   b. Offer a contract amendment to the Contractor to reflect the reduced funding for this contract

2. In the event that the State elects to offer an amendment, it shall be mutually understood by both parties that the State reserves the right to determine which contracts, if any, under this program shall be reduced and that some contracts may be reduced by a greater amount than others. The State shall determine, at its sole discretion, the amount that any or all of the contracts shall be reduced for the fiscal year.

B. The Contractor shall be reimbursed for Waivers Services expenses only as itemized in the most recent approved or revised Budget. Care Management and Care Management Support categories shall be reimbursed up to the combined budget amount of both categories.

C. Category amounts stipulated in the Budget, a part of Exhibit B, are the maximum amounts that may be reimbursed by DHCS under this Agreement or the actual category expenditures whichever is less. The Care Management and Care Management Support categories will be treated as a combined total budget for determining maximum allowable reimbursement amount.

D. The budget shall include the following line items:

1. Personnel Costs - monthly, weekly, or hourly rates, as appropriate and personnel classifications together with the percentage of time to be charged to this Agreement.

2. Fringe Benefits.

ARTICLE III. BUDGET AND BUDGET REVISION (CONTINUED)

3. Consultation, Professional Services-Contractual Costs, subcontract, and consultant cost detail.

4. Facility, Rent & Operations – specify square footage and rate.

5. Equipment Cost equal to or greater than $5,000 per Unit (Any Computing Equipment regardless of Cost) - detailed descriptions and unit costs needs to be identified on the Equipment tab in the Budget Template.

6. Travel (Include: In State and Out of State) – mileage reimbursement rate, lodging, per diem and other costs.

7. Equipment, Maintenance & Rental Costs; Supplies.

8. Indirect Costs shall not exceed fifteen percent (15%) of direct salaries plus benefits.

9. Other Costs - a detailed list of other operating expenses.

E. The Contractor shall obtain prior written approval from CDA to transfer funds between the Care Management and Care Management Support categories if the transfer amount is equal to or greater than five (5) percent of either category of the approved budget. This request shall be submitted on a Revised Budget Form. The Contractor must provide justification and supporting documentation for the requested revision.

F. Budgeting processes and conditions will be subject to instructions that will be issued to the Contractor under separate cover.

G. Equipment/Property with per unit cost of $5,000 or more, all computing devices regardless of cost (including but not limited to, workstations, servers, laptops, personal digital assistants, notebook computers, tablets, smartphones, and cellphones), and all portable electronic storage media regardless of cost (including but not limited to, thumb/flash drives and portable hard drives) requires justification and approval from CDA and must be included in its approved MSSP budget.

ARTICLE IV. DEFAULT PROVISIONS

The State, without limiting any rights which it may otherwise have, may, at its discretion and upon written notice to the Contractor, withhold further payments under this Agreement, and/or demand immediate repayment of the unliquidated balance of any advance payment hereunder, upon occurrence of any one of the following events:

A. Termination or suspension of this Agreement

B. A finding by the State that the Contractor:

1. Has failed to observe any of the covenants, conditions, or warrants of these provisions, or has failed to comply with any material provisions of this Agreement; or

2. Has failed to make progress, or is in such unsatisfactory financial condition, as to endanger performance of this Agreement; or

3. Has allocated inventory to this Agreement substantially exceeding reasonable requirements; or

4. Is delinquent in payment of taxes or of the cost of performance of this Agreement in the ordinary course of business

C. Appointment of a trustee, receiver, or liquidator for all or a substantial part of the Contractor's property, or institution of bankruptcy, reorganization, or arrangement of liquidation proceedings by or against the Contractor.

D. Service of any writ of attachment, levy, or execution, or commencement of garnishment proceeding or

E. The commission of an act of bankruptcy.

ARTICLE I. DEFINITIONS AND RESOLUTIONS OF LANGUAGE CONFLICTS

A. General Definitions

1. “Agreement” or “Contract” means the Standard Agreement (Std. 213), Exhibits A, B, C, D, E, F and G, an approved Budget as identified in Exhibit B, and if applicable, a Work Plan or Budget Summary, which are hereby incorporated by reference, amendments, and any other documents incorporated by reference; unless otherwise provided for in this Article.

2. "Contractor" means the governmental or nonprofit entity contracted with CDA to provide MSSP Waiver Services to eligible Medi-Cal beneficiaries on behalf of DHCS pursuant to an Interagency Agreement between DHCS and CDA.

3. “CCR” means California Code of Regulations.

4. “CFR” means Code of Federal Regulations.

5. “DUNS” means the nine-digit, Data Universal Numbering System number established and assigned by Dun and Bradstreet, Inc., to uniquely identify business entities.

6. “Cal. Gov. Code” means California Government Code.

7. “OMB” means the federal Office of Management and Budget.

8. “Cal. Pub. Con. Code” means the California Public Contract Code.

9. “Cal. Civ. Code” means California Civil Code

10. “Reimbursable item” also means “allowable cost” and “compensable item.”

11. “State” and “Department” mean the State of California and the California Department of Aging (CDA) interchangeably.

12. “Subcontractor” means the legal entity that receives funds from the Contractor to provide waiver services identified in this Agreement.

13. “Subcontract” means any form of legal agreement between the Contractor and the subcontractor, including an agreement that the Contractor considers a contract, including vendor type Agreements for providing goods or services under this Agreement.

14. “Vendor” means an entity selling goods or services to the Contractor or subcontractor during the Contractor or subcontractor’s performance of the Agreement.

ARTICLE I. DEFINITIONS AND RESOLUTIONS OF LANGUAGE CONFLICTS (Continued)

15. “Waiver participant” means any individual who has met MSSP eligibility requirements and been enrolled in the MSSP program.

16. “USC” means United States Code.

17. “OAA” means Older Americans Act.

18. “Allocation” means the process of assigning a cost, or a group of costs, to one or more cost objective(s), in reasonable proportion to the benefit provided or other equitable relationship. The process may entail assigning a cost(s) directly to a final cost objective or through one or more intermediate cost objectives. (2 CFR 200.1)

19. “Disallowed costs” means those charges determined to be unallowable, in accordance with the applicable Federal statutes, regulations, or the terms and conditions of the Federal award. (2 CFR 200.1)

20. “Questioned Costs” means a cost that is questioned by the auditor because of an audit finding which resulted from a violation or possible violation of a statute, regulation, or the terms and conditions of a Federal award, including for funds used to match Federal funds; where the costs, at the time of the audit, are not supported by adequate documentation; or where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances. (2 CFR 200.84).

21. “Recoverable cost” means the questioned cost identified from an audit.

22. "DHCS" means the Department of Health Care Services.

23. “HHS” means United States Department of Health and Human Services.

B. Resolution of Language Conflicts

Should the terms and conditions of this Agreement be found to conflict with one another, the following order of authority shall control:

1. Statutory law, subject to the doctrine of preemption, including, but not limited to: Section 1915(c) of Title XIX of the Social Security Act, 42 USC 1396n, Welfare and Institutions Code Sections 9560 to 9568, other Federal and California state codes and regulations governing the MSSP, and/or other applicable Federal and California state statutes and their implementing regulations.

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ARTICLE I. DEFINITIONS AND RESOLUTIONS OF LANGUAGE CONFLICTS (Continued)

2. Standard Agreement (Std. 213), all Exhibits and any amendments thereto.

3. Any other documents incorporated herein by reference including, as applicable, the MSSP Site Manual found at https://www.aging.ca.gov/Programs Providers/MSSP/.

4. Program memos and other guidance issued by CDA.

ARTICLE II. ASSURANCES

A. Law, Policy and Procedure, Licenses, and Certificates

The Contractor agrees to administer this Agreement and require any subcontractors to administer their subcontracts in accordance with this Agreement, and with all applicable local, State, and federal laws and regulations including, but not limited to, discrimination, wages and hours of employment, occupational safety, and to fire, safety, health, and sanitation regulations, directives, guidelines, and/or manuals related to this Agreement and resolve all issues using good administrative practices and sound judgment. The Contractor and its subcontractors shall keep in effect all licenses, permits, notices, and certificates that are required by law.

B. Subcontracts

The Contractor shall require language in all subcontracts to require all subcontractors to comply with all applicable State and federal laws.

C. Nondiscrimination

The Contractor shall comply with all federal statutes relating to nondiscrimination. These include those statutes and laws contained in the Contractor Certification Clauses (CCC 307), which is hereby incorporated by reference. In addition, the Contractor shall comply with the following:

1. Equal Access to Federally Funded Benefits, Programs and Activities

The Contractor shall ensure compliance with Title VI of the Civil Rights Act of 1964 [42 USC 2000d; 45 CFR 80], which prohibits recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

ARTICLE II. ASSURANCES (Continued)

2. Equal Access to State-Funded Benefits, Programs and Activities

The Contractor shall, unless exempted, ensure compliance with the requirements of Cal. Gov. Code § 11135 et seq., and 2 CCR § 11140 et seq., which prohibit recipients of state financial assistance from discriminating against persons based on race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability. [22 CCR § 98323]

3. California Civil Rights Laws

The Contractor shall, ensure compliance with the requirements of California Public Contract Code § 2010 by submitting a completed California Civil Rights Laws Certification, prior to execution of this Agreement.

The California Civil Rights Laws Certification ensures Contractor compliance with the Unruh Civil Rights Act (Cal. Civ. Code § 51) and the Fair Employment and Housing Act (Cal. Gov. Code § 12960) and ensures that Contractor internal policies are not used in violation of California Civil Rights Laws.

4. The Contractor assures the State that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. [42 USC 12101 et seq.]

5. The Contractor agrees to include these requirements in all contracts it enters into with subcontractors to provide services pursuant to this Agreement.

D. Standards of Work

The Contractor agrees that the performance of work and services pursuant to the requirements of this Agreement shall conform to accepted professional standards.

E. Conflict of Interest

1. The Contractor shall prevent employees, consultants, or members of governing bodies from using their positions for purposes including, but not limited to, the selection of subcontractors, that are, or give the appearance of being, motivated by a desire for private gain for themselves or others,

ARTICLE II. ASSURANCES (Continued)

such as family, business, or other ties. In the event that the State determines that a conflict of interest exists, any increase in costs associated with the conflict of interest may be disallowed by the State and such conflict may constitute grounds for termination of the Agreement.

2. This provision shall not be construed to prohibit employment of persons with whom the Contractor's officers, agents, or employees have family, business, or other ties, so long as the employment of such persons does not result in a conflict of interest (real or apparent) or increased costs over those associated with the employment of any other equally qualified applicant, and such persons have successfully competed for employment with the other applicants on a merit basis.

F. Covenant Against Contingent Fees

1. The Contractor warrants that no person or selling agency has been employed or retained to solicit this Agreement. There has been no agreement to make commission payments in order to obtain this Agreement.

2. For breach or violation of this warranty, CDA shall have the right to terminate this Agreement without liability or at its discretion to deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, brokerage, or contingency fee.

G. Payroll Taxes and Deductions

The Contractor shall promptly forward payroll taxes, insurances, and contributions, including State Disability Insurance, Unemployment Insurance, Old Age Survivors Disability Insurance, and federal and State income taxes withheld, to designated governmental agencies as required by law.

H. Facility Construction or Repair

1. When applicable for purposes of construction or repair of facilities, the Contractor shall comply with the provisions contained in the following and shall include such provisions in any applicable agreements with subcontractors:

ARTICLE II. ASSURANCES (Continued)

a. Copeland "Anti-Kickback" Act. [18 USC 874, 40 USC 3145] [29 CFR 3]

b. Davis-Bacon Act. [40 USC 3141 et seq.] [29 CFR 5]

c. Contract Work Hours and Safety Standards Act. [40 USC 3701 et seq.] [29 CFR 5, 6, 7, 8]

d. Executive Order 11246 of September 14, 1965, entitled "Equal Employment Opportunity" as amended by Executive Order 11375 of October 13, 1967, as supplemented in Department of Labor Regulations. [41 CFR 60]

2. Payments are not permitted for construction, renovation, alteration, improvement, or repair of privately-owned property which would enhance the owner's value of such property except where permitted by law and by CDA.

3. When funding is provided for construction and non-construction activities, the Contractor must obtain prior written approval from CDA before making any fund or budget transfers between construction and non-construction.

I. Contracts in Excess of $100,000

If all funding provided herein exceeds $100,000, the Contractor shall comply with all applicable orders or requirements issued under the following laws:

1. Clean Air Act, as amended. [42 USC 7401]

2. Federal Water Pollution Control Act, as amended. [33 USC 1251 et seq.]

3. Environmental Protection Agency Regulations. [40 CFR 29] [Executive Order 11738]

4. State Contract Act [Cal. Pub. Con. Code §10295 et seq.]

5. Unruh Civil Rights Act [Cal. Pub. Con. Code § 2010]

J. Debarment, Suspension, and Other Responsibility Matters

1. The Contractor certifies to the best of its knowledge and belief, that it and its subcontractors:

ARTICLE II. ASSURANCES (Continued)

a. Are not presently debarred, suspended, proposed for disbarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or agency.

b. Have not, within a three-year period preceding this 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) transaction or contract under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property.

c. 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 (1)(b) of this certification.

d. Have not, within a three-year period preceding this Agreement, had one or more public transactions (federal, State, or local) terminated for cause or default.

2. The Contractor shall report immediately to CDA in writing any incidents of alleged fraud and/or abuse by either the Contractor or subcontractors.

3. The Contractor shall maintain any records, documents, or other evidence of fraud and abuse until otherwise notified by CDA.

4. The Contractor agrees to timely execute any and all amendments to this Agreement or other required documentation relating to the Subcontractor's debarment/suspension status.

K. Agreement Authorization

1. If a public entity, the Contractor shall submit to CDA a copy of an approved resolution, order, or motion referencing this Agreement number authorizing execution of this Agreement. If a private nonprofit entity, the Contractor shall submit to CDA an authorization by the Board of Directors to execute this Agreement, referencing this Agreement number.

2. These documents, including minute orders, must also identify the action taken.

ARTICLE II. ASSURANCES (Continued)

3. Documentation in the form of a resolution, order, or motion by the Governing Board is required for the original and each subsequent amendment to this Agreement. This requirement may also be met by a single resolution from the Governing Board of the Contractor authorizing the Director or designee to execute the original and all subsequent amendments to this Agreement.

L. Contractor's Staff

1. The Contractor shall maintain adequate staff to meet the Contractor's obligations under this Agreement.

2. This staff shall be available to the State for training and meetings which the State may find necessary from time to time.

M. DUNS Number and Related Information

1. The DUNS number must be provided to CDA prior to the execution of this Agreement. Business entities may register for a DUNS number.

2. The Contractor must register the DUNS number and maintain an "Active" status within the federal System for Award Management.

3. If CDA cannot access or verify "Active" status the Contractor's DUNS information, which is related to this federal subaward on the Federal Funding Accountability and Transparency Act Subaward Reporting System (SAM.gov) due to errors in the Contractor's data entry for its DUNS number, the Contractor must immediately update the information as required.

N. Corporate Status

1. The Contractor shall be a public entity, private nonprofit entity, or Joint Powers Authority (JPA). If a private nonprofit corporation or JPA, the Contractor shall be in good standing with the Secretary of State of California and shall maintain that status throughout the term of this Agreement.

2. The Contractor shall ensure that any subcontractors providing services under this Agreement shall be of sound financial status.

3. Any subcontracting private entity or JPA shall be in good standing with the Secretary of State of California and shall maintain that status throughout the term of this Agreement.

ARTICLE II. ASSURANCES (Continued)

4. Failure to maintain good standing by the contracting entity shall result in suspension or termination of this Agreement with CDA until satisfactory status is restored. Failure to maintain good standing by a subcontracting entity shall result in suspension or termination of the subcontract by the Contractor until satisfactory status is restored.

O. Lobbying Certification

The Contractor, by signing this Agreement, hereby certifies to the best of its knowledge and belief, that:

1. No federally appropriated funds have been paid or will be paid, by or on behalf of the Contractor, to 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 the awarding of any federal contract; the making of any federal grant; the making of any federal loan; the entering into of any cooperative agreement; and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

2. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, 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, loan, or cooperative agreement, the Contractor shall complete and submit Standard Form-LLL, Disclosure Form to Report Lobbying, in accordance with its instructions.

3. The Contractor shall require that the language of this certification be included in the award documents for all subcontracts at all tiers (including contracts under grants, loans, and cooperative agreements which exceed $100,000) and that all subcontractors shall certify and disclose accordingly.

4. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into.

5. This certification is a prerequisite for making or entering into this transaction imposed by 31 USC 1352.

6. 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.

ARTICLE II. ASSURANCES (Continued)

P. The Contractor and its subcontractors/vendors shall comply with Governor's Executive Order 2-18-2011, which bans expenditures on promotional and marketing items colloquially known as "S.W.A.G." or "Stuff We All Get."

ARTICLE III. AGREEMENT

A copy of this executed Agreement is on file and available for inspection at the California Department of Aging, 2880 Gateway Oaks Drive, Suite 200, Sacramento, California 95833.

ARTICLE IV. COMMENCEMENT OF WORK

Should the Contractor or subcontractor begin work in advance of receiving notice that this Agreement is approved, that work may be considered as having been performed on a voluntary basis and may not be reimbursed or compensated.

ARTICLE V. SUBCONTRACTS

A. The Contractor is responsible for carrying out the terms of this Agreement, including the satisfaction, settlement, and resolution of all administrative, programmatic, and fiscal aspects of the program(s), including issues that arise out of any subcontracts, and shall not delegate or contract these responsibilities to any other entity. This includes, but is not limited to, disputes, claims, protests of award, or other matters of a contractual nature. The Contractor's decision is final, and the subcontractor(s) has no right of appeal to CDA.

B. The Contractor shall, in the event any subcontractor is utilized by the Contractor for any portion of this Agreement, retain the prime responsibility for all the terms and conditions set forth, including but not limited to, the responsibility for preserving the State's copyrights and rights in data in accordance with Article XIX of this Exhibit, for handling property in accordance with Article VII of this Exhibit, and ensuring the keeping of, access to, availability of, and retention of records of subcontractors in accordance with Article VI of this Exhibit.

C. The Contractor shall not obligate funds for this Agreement in any subcontracts for services beyond the ending date of this Agreement.

D. The Contractor shall have no authority to contract for, or on behalf of, or incur obligations on behalf of the State.

E. The Contractor shall maintain on file copies of subcontracts, memorandums and/or Letters of Understanding which shall be made available for review at the request of CDA.

ARTICLE V. SUBCONTRACTS (Continued)

F. The Contractor shall monitor the insurance requirements of its subcontractors in accordance with Article XI of this Exhibit.

G. The Contractor shall require language in all subcontracts to require all subcontractors to indemnify, defend, and save harmless the Contractor, its officers, agents, and employees from any and all claims and losses accruing to or resulting from any subcontractors, suppliers, laborers, and any other person, firm, or corporation furnishing or supplying work services, materials, or supplies in connection with any activities performed for which funds from this Agreement were used and from any and all claims and losses accruing or resulting to any person, firm, or corporation who may be injured or damaged by the subcontractor(s) in the performance of this Agreement.

H. The Contractor shall require all subcontractors to maintain adequate staff to meet the subcontractors' agreement with the Contractor. This staff shall be available to the State for training and meetings which the State may find necessary from time to time.

I. If a private nonprofit corporation, the subcontractor(s) shall be in good standing with the Secretary of State of California and shall maintain that status throughout the term of the Agreement.

J. The Contractor shall refer to 2 CFR 200.330, Subpart D - Subrecipient and Contractor Determinations and 45 CFR 75.351, Subpart D - Subrecipient and Contractor Determinations in making a determination if a subcontractor relationship exists. If such a relationship exists, then the Contractor shall follow the procurement requirements in the applicable OMB Circular.

K. The Contractor shall utilize procurement procedures as follows:

The Contractor shall obtain goods and services through open and competitive awards. Each Contractor shall have written policies and procedures, including application forms, for conducting an open and competitive process, and any protests resulting from the process.

ARTICLE VI. RECORDS

A. The Contractor shall maintain complete records which shall include, but not be limited to, accounting records, contracts, agreements, a reconciliation of the "Financial Closeout Report" (CDA Closeout) to the audited financial statements, single audit report, and general ledgers. This includes the following: Letters of Agreement, insurance documentation, memorandums and/or Letters of Understanding, waiver participant records, and electronic files of its activities and expenditures hereunder in a form satisfactory to CDA. All records pertaining to this Agreement must be made available for inspection and audit by

ARTICLE VI. RECORDS (Continued)

pertaining to this the State or its duly authorized agents, at any time during normal business hours.

B. All such records, including confidential records, must be maintained, and made available by the Contractor: (1) until an audit of the July 1 through June 30 fiscal period of expenditures has occurred and an audit resolution has been issued or unless otherwise authorized in writing by CDA's or DHCS' Audit Branch, (2) for such longer period, if any, as is required by applicable statute, by any other clause of this Agreement, or by Sections A and C of this Article, and (3) for such longer period as CDA deems necessary.

C. If this Agreement is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for the same periods as specified in Section A above. The Contractor shall ensure that any resource directories and all waiver participant records remain the property of CDA upon termination of this Agreement and are returned to CDA or transferred to another contractor as instructed by CDA.

D. In the event of any litigation, claim, negotiation, audit exception, or other action involving the records, all records relative to such action shall be maintained and made available until every action has been cleared to the satisfaction of CDA and DHCS and is so stated in writing to the Contractor.

E. Adequate source documentation of each transaction shall be maintained relative to the allowability of expenditures reimbursed by the DHCS under this Agreement. Source documentation includes, but is not limited to: vendor invoices, bank statements, cancelled checks, bank/credit card statements, contracts and agreements, employee time sheets, purchase orders, indirect cost allocation plans. If the allowability of expenditures cannot be determined because records or documentation of the Contractor are nonexistent or inadequate according to guidelines set forth in 2 CFR 200.302 and 45 CFR 75.302, the expenditures will be questioned in the audit and may be disallowed by CDA during the audit resolution process.

F. All records containing confidential information shall be handled in a confidential manner in accordance with the requirements for information integrity and security, and in accordance with guidelines set forth in this Article, and Article XVIII. After the authorized period has expired, confidential records shall be shredded and disposed of in a manner that will maintain confidentiality.

ARTICLE VII. PROPERTY

A. Unless otherwise provided for in this Article, property refers to all assets used in operation of this Agreement.

ARTICLE VII. PROPERTY (Continued)

1. Property includes land, buildings, improvements, machinery, vehicles, furniture, tools, and intangibles, etc.

2. Property does not include consumable office supplies such as paper, pencils, toner cartridges, file folders, etc.

3. Property, for the purpose of this MSSP Agreement, does not include any equipment or supplies acquired on behalf of the waiver participant.

B. Property acquired under this agreement, which meets any of the following criteria is subject to the reporting requirements:

1. Has a normal useful life of at least one (1) year and has a unit acquisition cost of at least $5,000 (a desktop or laptop setup, is considered a unit, if purchased as a unit).

2. All computing devices, regardless of cost (including but not limited to, workstations, servers, laptops, personal digital assistants, notebook computers, tablets, smartphones and cellphones).

3. All portable electronic storage media, regardless of cost (including but not limited to, thumb/flash drives and portable hard drives).

C. Additions, improvements, and betterments to assets meeting all of the conditions in Section B above must also be reported. Additions typically involve physical extensions of existing units. Improvements and betterments typically do not increase the physical size of the asset. Instead, improvements and betterments enhance the condition of an asset (e.g., extend life, increase service capacity, and lower operating costs). Examples of assets that might be improved and bettered include roads, bridges, curbs and gutters, tunnels, parking lots, streets and sidewalks, drainage, and lighting systems.

D. Intangibles are property which lack physical substance but give valuable rights to the owner. Examples of intangible property include patents, copyrights, leases, and computer software. By contrast, hardware consists of tangible equipment (e.g., computer printer, terminal, etc.). Costs include all amounts incurred to acquire and to ready the intangible asset for its intended use. Typical intangible property costs include the purchase price, legal fees, and other costs incurred to obtain title to the asset.

E. The Contractor shall keep track of property purchased with funds from this Agreement and submit to CDA a Property Acquisition Form (CDA 9023) for all property furnished or purchased by either the Contractor or the subcontractor with funds awarded under the terms of this Agreement, as instructed by CDA. The Contractor shall certify their reported property inventory annually by completing the Program Property Inventory Certification (CDA 9024).

ARTICLE VII. PROPERTY (Continued)

The Contractor shall record, at minimum, the following information when property is acquired:

1. Date acquired.

2. Item description (include model number).

3. CDA tag number.

4. Serial number (if applicable).

5. Purchase cost or other basis of valuation.

6. Fund source.

F. Disposal of Property

1. Prior to disposal of any property purchased by the Contractor or the subcontractor with funds from this Agreement or any predecessor Agreement, the Contractor must obtain approval from CDA for all reportable property as defined in Section B of this Article. Disposition, which includes sale, trade-in, discarding, or transfer to another agency may not occur until approval is received from CDA. The Contractor shall email to CDA the electronic version of the Request to Dispose of Property (CDA 248). CDA will then instruct the Contractor on disposition of the property. Once approval for disposal has been received from CDA and the Contractor has reported to CDA the Property Survey Report's (STD 152) Certification of Disposition, the item(s) shall be removed from the Contractor's inventory report.

2. The Contractor must remove all confidential, sensitive, or personal information from CDA property prior to disposal, including removal or destruction of data on computing devices with digital memory and storage capacity. This includes, but is not limited to magnetic tapes, flash drives, personal computers, personal digital assistants, cell or smart phones, multi-function printers, and laptops.

G. Any loss, damage, or theft of equipment shall be investigated, fully documented and the Contractor shall promptly notify CDA.

H. The State reserves title to all State-purchased or financed property not fully consumed in the performance of this Agreement, unless otherwise required by federal law or regulations or as otherwise agreed by the parties.

ARTICLE VII. PROPERTY (Continued)

I. The Contractor shall exercise due care in the use, maintenance, protection, and preservation of such property during the period of the project and shall assume responsibility for replacement or repair of such property during the period of the project, or until the Contractor has complied with all written instructions from CDA regarding the final disposition of the property.

J. In the event of the Contractor's dissolution or upon termination of this Agreement, the Contractor shall provide a final property inventory to the State. The State reserves the right to require the Contractor to transfer such property to another entity, or to the State.

K. To exercise the above right, no later than one hundred twenty (120) days after termination of this Agreement or notification of the Contractor's dissolution, the State will issue specific written disposition instructions to the Contractor.

L. The Contractor shall use the property for the purpose for which it was intended under the Agreement. When no longer needed for that use, the Contractor shall use it, if needed, and with written approval of the State for other purposes in this order:

1. For another CDA program providing the same or similar service.

2. For another CDA-funded program.

M. The Contractor may share use of the property and equipment or allow use by other programs, upon written approval from CDA. As a condition of the approval, CDA may require reimbursement under this Agreement for its use.

N. The Contractor or subcontractors shall not use equipment or supplies acquired under this Agreement with federal and/or State monies for personal gain or to usurp the competitive advantage of a privately-owned business entity.

O. If purchase of equipment is a reimbursable item, the equipment to be purchased will be specified in the Budget.

P. The Contractor shall include the provisions contained in this Article in all its subcontracts awarded under this Agreement.

ARTICLE VIII. ACCESS

The Contractor shall provide access to the federal or State contracting agency, the California State Auditor, the Comptroller, General of the United States, or any of their duly authorized

ARTICLE VIII. ACCESS (Continued)

federal or State representatives to any books, documents, papers, and records of the Contractor or subcontractor which are directly pertinent to this specific Agreement for the purpose of making an audit, examination, excerpts, and transcriptions. The Contractor shall include this requirement in its subcontracts.

ARTICLE IX. MONITORING AND EVALUATION

A. Authorized State representatives shall have the right to monitor and evaluate the Contractor's administrative, fiscal and program performance pursuant to this Agreement. Said monitoring and evaluation may include, but is not limited to, administrative processes, fiscal, data and procurement components. This will include policies, procedures, procurement, audits, inspections of project premises, interviews of project staff and participants, and when applicable, inspection of food preparation sites.

B. The Contractor shall cooperate with the State in the monitoring and evaluation processes, which include making any administrative, program and fiscal staff available during any scheduled process.

C. The Contractor shall monitor contracts and subcontracts to ensure compliance with laws, regulations, and the provisions of contracts that may have a direct and/or material effect on each of its CDA/DHCS funded programs.

D. The Contractor is responsible for maintaining supporting documentation including financial and statistical records, contracts, subcontracts, monitoring reports, and all other pertinent records until an audit has occurred and an audit resolution has been issued or unless otherwise authorized in writing by CDA.

ARTICLE X. AUDIT REQUIREMENTS

A. General

1. Any duly authorized representative of the federal or State government, which includes but is not limited to the State Auditor, CDA Staff, and any entity selected by State to perform inspections, shall have the right to monitor and audit Contractor and all subcontractors providing services under this Agreement through on-site inspections, audits, and other applicable means the State determines necessary. In the event that CDA is informed of an audit by an outside federal or State government entity affecting the Contractor, CDA will provide timely notice to Contractor.

2. Contractor shall make available all reasonable information necessary to substantiate that expenditures under this agreement are allowable and

ARTICLE X. AUDIT REQUIREMENTS (Continued)

allocable, including, but not limited to accounting records, vendor invoices, bank statements, cancelled checks, bank/credit card statements, contracts and agreements, employee time sheets, purchase orders, indirect cost allocation plans. Contractor shall agree to make such information available to the federal government, the State, or any of their duly authorized representatives, including representatives of the entity selected by State to perform inspections, for examination, copying, or mechanical reproduction, on or off the premises of the appropriate entity upon a reasonable request.

3. All agreements entered into by Contractor and subcontractors with audit firms for purposes of conducting independent audits under this Agreement shall contain a clause permitting any duly authorized representative of the federal or State government access to the supporting documentation of said audit firm(s).

4. The Contractor shall cooperate with and participate in any further audits which may be required by the State, including CDA fiscal and compliance audits.

B. CDA Fiscal and Compliance Audits

1. The CDA Audits and Risk Management Branch shall perform fiscal and compliance audits of Contractors in accordance with Generally Accepted Government Auditing Standards (GAGAS) to ensure compliance with applicable laws, regulations, grants, and contract requirements.

2. The CDA fiscal and compliance audits may include, but not be limited to, a review of:

a. Financial closeouts (2 CFR 200.1)

b. Internal controls (2 CFR 200.303)

c. Allocation of expenditures (2 CFR 200.1)

d. Allowability of expenditures (2 CFR 200.403)

e. Equipment expenditures and approvals, if required (2 CFR 200.439)

C. Single Audit Reporting Requirements (2 CFR 200 Subpart F and 45 CFR 75 Subpart F)

1. Contractor Single Audit Reporting Requirements

ARTICLE X. AUDIT REQUIREMENTS (Continued)

a. Contractors that expend $1,000,000 or more in federal funds shall arrange for an audit to be performed as required by the Single Audit Act of 1984, Public Law 98-502; the Single Audit Act Amendments of 1996, Public Law 104-156; and 2 CFR 200.501 to 200.521. A copy shall be submitted to the:

California Department of Aging
Attention: Audits and Risk Management Branch
2880 Gateway Oaks Drive, Suite 200
Sacramento, California 95833

b. The copy shall be submitted within thirty (30) days after receipt of the Auditor's report or nine (9) months after the end of the audit period, whichever occurs first, or unless a longer period is agreed to in advance by the cognizant or oversight agency.

c. For purposes of reporting, the Contractor shall ensure that State-funded expenditures are displayed discretely along with the related federal expenditures in the single audit report's "Schedule of Expenditures of Federal Awards" (SEFA) under the Catalog of Federal Domestic Assistance (CFDA) number.

d. For State contracts that do not have CFDA numbers, the Contractor shall ensure that the State-funded expenditures are discretely identified in the SEFA by the appropriate program name, identifying grant/contract number, and as passed through CDA.

2. The Contractor shall perform a reconciliation of the "Financial Closeout Report" to the audited financial statements, single audit, and general ledgers. The reconciliation shall be maintained and made available for CDA review.

3. Contract Resolution of Contractor's Subrecipients

The Contractor shall have the responsibility for resolving its contracts with subcontractors to determine whether funds provided under this Agreement are expended in accordance with applicable laws, regulations, and provisions of contracts or agreements. The Contractor shall, at a minimum, perform Contract resolution within fifteen (15) months of the "Financial Closeout Report."

4. The Contractor shall ensure that subcontractor single audit reports meet 2 CFR 200, Subpart F-Audit Requirements

ARTICLE X. AUDIT REQUIREMENTS (Continued)

5. Contract resolution includes:

   a. Ensuring that subcontractors expending $750,000 or more in federal awards during the subcontractor's fiscal year have met the audit requirements of 2 CFR 200.501 - 200.521.

   b. Issuing a management decision on audit findings within six (6) months after receipt of the Subcontractor's single audit report and ensuring that the Subcontractor takes appropriate and timely corrective action.

   c. Reconciling expenditures reported to the Contractor to the amounts identified in the single audit or other type of audit if the subcontractor was not subject to the single audit requirements. For a subcontractor who was not required to obtain a single audit and did not obtain another type of audit, the reconciliation of expenditures reported to CDA must be accomplished through performing alternative procedures (e.g., risk assessment [2 CFR 200.331], documented review of financial statements, and documented expense verification, including match, etc.).

6. When alternative procedures are used, the Contractor shall perform financial management system testing, which provides, in part, for the following:

   a. Accurate, current, and complete disclosure of the financial results of each federal award or program.

   b. Records that identify adequately the source and application of funds for each federally funded activity.

   c. Effective control over, and accountability for, all funds, property, and other assets to ensure these items are used solely for authorized purposes.

   d. Comparison of expenditures with budget amounts for each federal award.

   e. Written procedures to implement the requirements of 2 CFR 200.305.

   f. Written procedures for determining the allowability of costs in accordance with 2 CFR Part 200, Subpart E - Cost Principles. [2 CFR 200.302]

ARTICLE X. AUDIT REQUIREMENTS (Continued)

g. The Contractor shall document system and expense testing to show an acceptable level of reliability, including a review of actual source documents.

h. Determining whether the results of the reconciliations performed necessitate adjustment of the Contractor's own records.

7. The Contractor shall ensure that subcontractor single audit reports meet 2 CFR 200, Subpart F - Audit Requirements:

a. Performed timely – not less frequently than annually and a report submitted timely. The audit is required to be submitted within thirty (30) days after receipt of the Auditor's report or nine (9) months after the end of the audit period, whichever occurs first. [2 CFR 200 512]

b. Properly procured – use procurement standards for auditor selection. [2 CFR 200.509]

c. Performed in accordance with Generally Accepted Government Auditing Standards. [2 CFR 200.514]

d. All inclusive – includes an opinion (or disclaimer of opinion) of the financial statements; a report on internal control related to the financial statements and major programs; an opinion (or disclaimer of opinion) on compliance with laws, regulations, and the provisions of contracts; and the schedule of findings and questioned costs. [2 CFR 200.515]

e. Performed in accordance with provisions applicable to this program as identified in 2 CFR Part 200, Subpart F, Audit Requirements.

8. Requirements identified in Sections D and E of this Article shall be included in contracts with subcontractor(s). Further, the subcontractor(s) shall be required to include in its contract with the independent Auditor that the Auditor will comply with all applicable audit requirements/standards; CDA shall have access to all audit reports and supporting work papers, and CDA has the option to perform additional work, as needed.

ARTICLE X. AUDIT REQUIREMENTS (Continued)

9. The Contractor shall prepare a summary worksheet of results from the contract resolutions performed of all subcontractors. The summary worksheet shall include, but not be limited to, contract amounts; amounts resolved; amounts of match verified, resolution of variances; recovered amounts; whether an audit was relied upon or the Contractor performed an independent expense verification review (alternative procedures) of the subcontractor in making a determination; whether audit findings were issued; and, if applicable, issuance date of the management letter; and any communication or follow-up performed to resolve the findings.

10. A reasonably proportionate share of the costs of audits required by, and performed in, accordance with the Single Audit Act Amendments of 1996, as implemented by requirements of this part, are allowable. However, the following audit costs are unallowable:

    a. Any costs when audits required by the Single Audit Act and 2 CFR 200, Subpart F – Audit Requirements have not been conducted or have been conducted but not in accordance therewith; and

    b. Any costs of auditing a non-federal entity that is exempted from having an audit conducted under the Single Audit Act and 2 CFR 200, Subpart F – Audit Requirements because its expenditures under federal awards are less than $1,000,000 during the non-federal entity's fiscal year.

        i. The costs of a financial statement audit of a non-federal entity that does not currently have a federal award may be included in the indirect cost pool for a cost allocation plan or indirect cost proposal.

        ii. Pass-through entities may charge federal awards for the cost of agreed-upon-procedures engagements to monitor subcontractors who are exempted from the requirements of the Single Audit Act and 2 CFR 200, Subpart F – Audit Requirements. This cost is allowable only if the agreed-upon procedures engagements are conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS) attestation standards, paid for and arranged by the pass-through entity, and limited in scope to one or more of the following types of compliance requirements: activities allowed or not allowed; allowable costs/cost principles; eligibility; and reporting.
        [2 CFR 200.425]

ARTICLE X. AUDIT REQUIREMENTS (Continued)

D. The Contractor shall cooperate with and participate in any further audits which may be required by the State.

ARTICLE XI. INSURANCE

A. Prior to commencement of any work under this Agreement, the Contractor shall provide for the term of this Agreement, the following insurance:

1. General liability of not less than $1,000,000 per occurrence for bodily injury and property damage combined. Higher limits may be required by the State in cases of higher than usual risks.

2. Automobile liability including non-owned auto liability, of not less than $1,000,000 for volunteers and paid employees providing services supported by this Agreement.

3. If applicable, or unless otherwise amended by future regulation, the Contractor and subcontractors shall comply with the Public Utilities Commission General Order No. 115-F which requires higher levels of insurance for charter-party carriers of passengers and is based on seating capacity as follows:

   a. $750,000 if seating capacity is under 8

   b. $1,500,000 if seating capacity is 8 – 15

   c. $5,000,000 if seating capacity is over 15

4. Professional liability of not less than $1,000,000 as it appropriately relates to the services rendered. Coverage shall include medical malpractice and/or errors and omissions. (All programs except Title V).

B. The insurance will be obtained from an insurance company acceptable to the Department of General Services, Office of Risk and Insurance Management (DGS, ORIM), or be provided through partial or total self-insurance acceptable to the Department of General Services (DGS).

C. Evidence of insurance shall be in a form and content acceptable to DGS, ORIM.

D. The Contractor shall notify the State within five (5) business days of any cancellation, non-renewal, or material change that affects required insurance coverage.

ARTICLE XI. INSURANCE (Continued)

E. Insurance obtained through commercial carriers shall meet the following requirements:

1. The Certificate of Insurance shall provide the statement: "The Department of Aging, State of California, its officers, agents, employees, and servants are included as additional insureds, with respect to work performed for the State of California under this Agreement." Professional liability coverage is exempt from this requirement.

2. CDA shall be named as the certificate holder and CDA's address must be listed on the certificate.

F. The insurance provided herein shall be in effect at all times during the term of this Agreement. In the event the insurance coverage expires during the term of this Agreement, the Contractor agrees to provide CDA, at least thirty (30) days prior to the expiration date, a new Certificate of Insurance evidencing insurance coverage as provided herein for a period not less than the remaining Agreement term or for a period not less than one (1) year. In the event the Contractor fails to keep in effect at all times said insurance coverage, CDA may, in addition to any other remedies it may have, terminate this Agreement.

G. The Contractor shall require its subcontractors under this Agreement, other than units of local government which are similarly self-insured, to maintain insurance appropriate to the work to be performed, in alignment with industry standards and the requirements set forth in the California Civil Code, California Public Contracting Code, and the relevant sections of the California Insurance Code. This insurance shall be for general liability, Worker's Compensation liabilities, and if appropriate, auto liability including non-owned auto and professional liability, and/or any other form of insurance as may be proper in the industry in which the Contractor is performing under this Agreement. Further, the Contractor shall require all of its subcontractors to hold the Contractor harmless. The subcontractor's Certificate of Insurance for general and auto liability shall also name the Contractor, not the State, as the certificate holder and additional insured. The Contractor shall maintain Certificates of Insurance for all of its subcontractors.

H. A copy of each appropriate Certificate of Insurance or letter of self-insurance, referencing this Agreement number shall be submitted to CDA with this Agreement.

I. The Contractor shall be insured against liability for Worker's Compensation or undertake self-insurance in accordance with the provisions of the Labor Code and the Contractor affirms to comply with such provisions before commencing the performance of the work under this Agreement. [Labor Code § 3700]

ARTICLE XII. TERMINATION

A. Termination Without Cause

CDA may terminate performance of work under this Agreement, in whole or in part, without cause, if CDA determines that a termination is in the State's best interest. CDA may terminate the Agreement upon ninety (90) days written notice to the Contractor. The Notice of Termination shall specify the extent of the termination and shall be effective ninety (90) days from the delivery of the Notice. The parties agree that if the termination of the Contract is due to a reduction or deletion of funding by the Department of Finance (DOF), Legislature or Congress, the Notice of Termination shall be effective thirty (30) days from the delivery of the Notice. The Contractor shall submit to CDA a Transition Plan as specified in Exhibit E of this Agreement. The parties agree that, apart from the terminated portion of the Agreement, the remainder of the Agreement shall be deemed to remain in effect and is not void.

B. Termination for Cause

CDA may terminate, in whole or in part, for cause the performance of work under this Agreement. CDA may terminate the Agreement upon thirty (30) days' written notice to the Contractor. The Notice of Termination shall be effective thirty (30) days from the delivery of the Notice of Termination unless the grounds for termination are due to threat to life, health, or safety of the public and in that case, the termination shall take effect immediately. The Contractor shall submit to CDA a Transition Plan as specified in Exhibit E of this Agreement. The grounds for termination for cause shall include, but are not limited to, the following:

1. A violation of the law or failure to comply with any condition of this Agreement.

2. Inadequate performance or failure to make progress so as to endanger performance of this Agreement.

3. Failure to comply with reporting requirements.

4. Evidence that the Contractor is in an unsatisfactory financial condition as determined by an audit of the Contractor or evidence of a financial condition that endangers performance of this Agreement and/or the loss of other funding sources.

5. Delinquency in payment of taxes or payment of costs for performance of this Agreement in the ordinary course of business.

ARTICLE XII. TERMINATION (Continued)

6. Appointment of a trustee, receiver, or liquidator for all or a substantial part of the Contractor's property, or institution of bankruptcy, reorganization, or the arrangement of liquidation proceedings by or against the Contractor.

7. Service of any writ of attachment, levy of execution, or commencement of garnishment proceedings against the Contractor's assets or income.

8. The commission of an act of bankruptcy.

9. Finding of debarment or suspension. [Article II J]

10. The Contractor's organizational structure has materially changed.

11. CDA determines that the Contractor may be considered a "high risk" agency as described in 2 CFR 200.205 and 45 CFR 75.205. If such a determination is made, the Contractor may be subject to special conditions or restrictions.

12. In case of threat of life, health, or safety of the public, termination of the Agreement shall be effective immediately.

C. Contractor's Obligation After Notice of Termination

After receipt of a Notice of Termination, and except as directed by CDA, the Contractor shall immediately proceed with the following obligations, as applicable, regardless of any delay in determining or adjusting any funds due under this clause.

The Contractor shall:

1. Stop work as specified in the Notice of Termination.

2. Place no further subcontracts for materials or services, except as necessary, to complete the continued portion of the Contract.

3. Terminate all subcontracts to the extent they relate to the work terminated.

4. Settle all outstanding liabilities and termination settlement proposals arising from the termination of subcontracts, (the approval or ratification of which will be final for purposes of this clause).

ARTICLE XII. TERMINATION (Continued)

D. Effective Date

Termination of this Agreement shall take effect immediately in the case of an emergency such as threat to life, health, or safety of the public. The effective date for Termination with Cause or for funding reductions is thirty (30) days. Termination without Cause is ninety (90) days subsequent to written notice to the Contractor. The notice shall be in writing and describe the action being taken by CDA, the reason for such action, and any conditions of the termination, including the date of termination.

E. Voluntary Termination of Area Plan Agreement (Title III Only)

Pursuant to 22 CCR 7210, the Contractor may voluntarily terminate its contract prior to its expiration either by mutual agreement with CDA or upon thirty (30) days written notice to CDA. In case of voluntary termination, the Contractor shall allow CDA up to one hundred eighty (180) days to transition services. The Contractor shall submit a Transition Plan in accordance with Exhibit E of this Agreement.

F. Notice of Intent to Terminate by Contractor (All other non-Title III Programs)

In the event the Contractor no longer intends to provide services under this Agreement, the Contractor shall give CDA Notice of Intent to Terminate. Such notice shall be given in writing to CDA at least one hundred eighty (180) days prior to the proposed termination date. Unless mutually agreed upon, the Contractor does not have the authority to determine the date of termination of the Agreement. The Notice of Intent to Terminate shall include the reason for such action and the anticipated last day of work. The Contractor shall submit a Transition Plan in accordance with Exhibit E.

G. In the Event of a Termination Notice

CDA will present written notice to the Contractor of any condition, such as, but not limited to, transfer of waiver participants, care of waiver participants, return of unspent funds; and disposition of property, which must be met prior to termination.

ARTICLE XIII. REMEDIES

The Contractor agrees that any remedy provided in this Agreement is in addition to and not in derogation of any other legal or equitable remedy available to CDA as a result of breach of this Agreement by the Contractor, whether such breach occurs before or after completion of the project.

ARTICLE XIV. DISSOLUTION OF ENTITY

The Contractor shall notify CDA immediately of any intention to discontinue existence of the entity or to bring an action for dissolution.

ARTICLE XV. AMENDMENTS, REVISIONS OR MODIFICATIONS

A. No amendment or variation of the terms of this Agreement shall be valid unless made in writing, signed and approved through the State amendment process in accordance with the State Contract Manual. No oral understanding or agreement not incorporated in this Agreement is binding on any of the parties.

B. The State reserves the right to revise, waive, or modify the Agreement to reflect any restrictions, limitations, or conditions enacted by Congress or the Legislature or as directed by the Executive Branch of State government.

ARTICLE XVI. NOTICES

A. Any notice to be given hereunder by either party to the other may be affected by personal delivery in writing or by registered or certified mail, overnight mail, postage prepaid, return receipt requested, provided the Contractor retains receipt, and shall be communicated as of actual receipt.

B. The Contractor must notify CDA of any change of legal name, main address, or name of the Director. This notice shall be addressed to the MSSP Bureau Manager on the Contractor's letterhead.

1. The Contractor must notify CDA within thirty-five (35) days of relocation.
2. In addition, any change of address or name also requires an Agency Contract Representative form to be submitted to Business Management Bureau as stated in Exhibit D, Article XVII.

C. All other notices with the exception of those identified in Section B of this Article shall be addressed to the California Department of Aging, Multipurpose Senior Services Program Bureau, 2880 Gateway Oaks, Suite 200, Sacramento, California, 95833. Notices mailed to the Contractor shall be to the address indicated on the coversheet of this Agreement.

D. Either party may change its address by written notice to the other party in accordance with this Article.

ARTICLE XVII. DEPARTMENT CONTACT

A. The name of CDA's contact to request revisions, waivers, or modifications affecting this Agreement, will be provided by the State to the Contractor upon full execution of this Agreement.

ARTICLE XVII. DEPARTMENT CONTACT (Continued)

B. The Contractor shall, upon request from CDA, submit the name of its Agency Contract Representative (ACR) for this Agreement by submitting an Agency Contract Representative form to CDA's Business Management Bureau (BMB). This form requires the ACR's address, phone number, email address, and FAX number to be included on this form. For any change in this information, the Contractor shall submit an amended Agency Contract Representative form to the same address. This form may be requested from CDA's BMB.

ARTICLE XVIII. INFORMATION INTEGRITY, AND SECURITY

A. Information Assets

The Contractor, and its subcontractors/vendors, shall have in place operational policies, procedures, and practices to protect State information assets, including those assets used to store or access Personal Health Information (PHI), Personal Information (PI) and any information protected under the Health Insurance Portability and Accountability Act (HIPAA), (i.e., public, confidential, sensitive and/or personal identifying information) as specified in the State Administrative Manual, 5300 to 5365.3; Cal. Gov.
Code § 11019.9, DGS Management Memo 06-12; DOF Budget Letter 06-34; and CDA Program Memorandum 07-18 Protection of Information Assets and the Statewide Health Information Policy Manual.

Information assets may be in hard copy or electronic format and may include but is not limited to:

1. Reports
2. Notes
3. Forms
4. Computers, laptops, cellphones, printers, scanners
5. Networks (LAN, WAN, WIFI) servers, switches, routers
6. Storage media, hard drives, flash drives, cloud storage
7. Data, applications, databases

B. Encryption of Computing Devices

The Contractor, and its subcontractors/vendors, are required to use 128-Bit encryption for data collected under this Agreement that is confidential, sensitive, and/or personal information including data stored on all computing devices (including but not limited to, workstations, servers, laptops, personal digital assistants, notebook computers and backup media) and/or portable electronic

ARTICLE XVIII. INFORMATION INTEGRITY, AND SECURITY (Continued)

storage media (including but not limited to, discs, thumb/flash drives, portable hard drives, and backup media).

C. Disclosure

1. The Contractor, and its subcontractors/vendors, shall ensure that all confidential, sensitive and/or personal identifying information is protected from inappropriate or unauthorized access or disclosure in accordance with applicable laws, regulations, and State policies.

2. The Contractor, and its subcontractors/vendors, shall protect from unauthorized disclosure, confidential, sensitive and/or personal identifying information such as names and other identifying information concerning persons receiving services pursuant to this Agreement, except for statistical information not identifying any participant.

3. “Personal Identifying information” shall include, but not be limited to: name; identifying number; social security number; state driver’s license or state identification number; financial account numbers; and symbol or other identifying characteristic assigned to the individual, such as finger or voice print or a photograph.

4. The Contractor, and its subcontractors/vendors, shall not use confidential, sensitive and/or personal identifying information above for any purpose other than carrying out the Contractor’s obligations under this Agreement. The Contractor and its Subcontractors are authorized to disclose and access identifying information for this purpose as required by OAA.

5. The Contractor and its subcontractors/vendors, shall not, except as otherwise specifically authorized or required by this Agreement or court order, disclose any identifying information obtained under the terms of this Agreement to anyone other than CDA without prior written authorization from CDA. The Contractor may be authorized, in writing, by a participant to disclose identifying information specific to the authorizing participant.

6. The Contractor, and its subcontractors/vendors, may allow a participant to authorize the release of information to specific entities, but shall not request or encourage any participant to give a blanket authorization or sign a blank release, nor shall the Contractor accept such blanket authorization from any participant.

D. Security Awareness Training

1. The Contractor’s employees, subcontractors/vendors, and volunteers handling confidential, sensitive and/or personal identifying information

ARTICLE XVIII. INFORMATION INTEGRITY, AND SECURITY (Continued)

must complete the required CDA Security Awareness Training module within thirty (30) days of the start date of the Contract/Agreement, within thirty (30) days of the start date of any new employee, subcontractor, vendor or volunteer's employment and annually thereafter.

2. The Contractor must maintain certificates of completion on file and provide them to CDA upon request.

E. Health Insurance Portability and Accountability Act (HIPAA)

The Contractor agrees to comply with the privacy and security requirements of HIPAA and ensure that subcontractors/vendors comply with the privacy and security requirements of HIPAA.

F. Information Integrity and Security Statement

The Contractor shall sign and return an Information Integrity and Security Statement (CDA 1024) form with this Agreement. This is to ensure that the Contractor is aware of, and agrees to comply with, their obligations to protect CDA information assets from unauthorized access and disclosure.

G. Security Incident Reporting

A security incident occurs when CDA information assets are or are reasonably believed to have been accessed, modified, destroyed, or disclosed without proper authorization, or are lost or stolen. The Contractor, and its subcontractors/vendors, must comply with CDA's security incident reporting procedure.

H. Security Breach Notifications

Notice must be given by the Contractor, and/or its subcontractors/vendors to anyone whose confidential, sensitive and/or personal identifying information could have been breached in accordance with HIPAA, the Information Practices Act of 1977, and State policy.

I. Software Maintenance

The Contractor, and its subcontractors/vendors, shall apply security patches and upgrades in a timely manner and keep virus software up to date on all systems on which State data may be stored or accessed.

J. Electronic Backups

ARTICLE XVIII. INFORMATION INTEGRITY, AND SECURITY (Continued)

The Contractor, and its subcontractors/vendors, shall ensure that all electronic information is protected by performing regular backups of files and databases and ensure the availability of information assets for continued business. The Contractor, and its subcontractors/vendors, shall ensure that all data, files and backup files are encrypted.

K. Provisions of this Article

The provisions contained in this Article shall be included in all contracts of both the Contractor and its subcontractors/vendors.

ARTICLE XIX. COPYRIGHTS AND RIGHTS IN DATA

A. Copyrights

1. If any material funded by this Agreement is subject to copyright, the State reserves the right to copyright such material and the Contractor agrees not to copyright such material, except as set forth in Section B of this Article.

2. The Contractor may request permission to copyright material by writing to the Director of CDA. The Director shall grant permission or give reason for denying permission to the Contractor in writing within sixty (60) days of receipt of the request.

3. If the material is copyrighted with the consent of CDA, the State reserves a royalty-free, non-exclusive, and irrevocable license to reproduce, prepare derivative works, publish, distribute and use such materials, in whole or in part, and to authorize others to do so, provided written credit is given to the author.

4. The 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 contract for the acquisition, operation, or maintenance of computer software in violation of copyright laws.

B. Rights in Data

1. The Contractor shall not publish or transfer any materials, as defined in paragraph 2 below, produced or resulting from activities supported by this Agreement without the express written consent of the Director of CDA. That consent shall be given, or the reasons for denial shall be given, and any conditions under which it is given or denied, within thirty (30) days after the written request is received by CDA. CDA may request a copy of the material for review prior to approval of the request. This subsection is not intended to prohibit the Contractor from sharing identifying waiver

ARTICLE XIX. COPYRIGHTS AND RIGHTS IN DATA (Continued)

participant information authorized by the participant or summary program information which is not waiver participant specific.

2. As used in this Agreement, the term "subject data" means writings, sound recordings, pictorial reproductions, drawings, designs or graphic representations, procedural manuals, forms, diagrams, workflow charts, equipment descriptions, data files and data processing or computer programs, and works of any similar nature (whether or not copyrighted or copyrightable) which are first produced or developed under this Agreement. The term does not include financial reports, cost analyses and similar information incidental to contract administration.

3. Subject only to other provisions of this Agreement, the State may use, duplicate, or disclose in any manner, and have or permit others to do so subject to State and federal law, all subject data delivered under this Agreement.

ARTICLE XX. BILINGUAL AND LINGUISTIC PROGRAM SERVICES

A. Needs Assessment

1. The Contractor shall conduct a cultural and linguistic group-needs assessment of the eligible waiver participant population in the Contractor's service area to assess the language needs of the population and determine what reasonable steps are necessary to ensure meaningful access to services and activities to eligible individuals. [22 CCR 98310, 98314]

   The group-needs assessment shall take into account the following four (4) factors:

   a. Number or proportion of persons with Limited English Proficiency (LEP) eligible to be served or encountered by the program.

   b. Frequency with which LEP individuals come in contact with the program.

   c. Nature and importance of the services provided.

   d. Local or frequently used resources available to the Contractor.

   This group-needs assessment will serve as the basis for the Contractor's determination of "reasonable steps" and provide documentary evidence of compliance with Cal. Gov. Code § 11135 et seq.; 2 CCR 11140, 2 CCR 11200 et seq., and 22 CCR98300 et seq.

ARTICLE XX. BILINGUAL AND LINGUISTIC PROGRAM SERVICES (Continued)

2. The Contractor shall prepare and make available a report of the findings of the group-needs assessment that summarizes:

   a. Methodologies used.

   b. The linguistic and cultural needs of non-English speaking or LEP groups.

   c. Services proposed to address the needs identified and a timeline for implementation. [22 CCR 98310]

3. The Contractor shall maintain a record of the group-needs assessment on file at the Contractor's headquarters at all times during the term of this Agreement. [22 CCR 98310, 98313]

B. Provision of Services

1. The Contractor shall take reasonable steps, based upon the group-needs assessment identified in Section A of this Article, to ensure that "alternative communication services" are available to non-English speaking or LEP beneficiaries of services under this Agreement. [22 CCR 11162]

2. "Alternative communication services" include, but are not limited to, the provision of services and programs by means of the following:

   a. Interpreters or bilingual providers and provider staff.

   b. Contracts with interpreter services.

   c. Use of telephone interpreter lines.

   d. Sharing of language assistance materials and services with other providers.

   e. Translated written information materials, including but not limited to, enrollment information and descriptions of available services and programs.

   f. Referral to culturally and linguistically appropriate community service programs.

3. Based upon the findings of the group-needs assessment, the Contractor shall ensure that reasonable alternative communication services are available to meet the linguistic needs of identified eligible waiver participant population groups at key points of contact. Key points of contact include, but are not limited to, telephone contacts, office visits and

in-home visits.
[22 CCR 11162]

The Contractor shall self-certify to compliance with the requirements of this section and shall maintain the self-certification record on file at the Contractor's office at all times during the term of this Agreement.
[22 CCR 98310]

4. The Contractor shall notify its employees of waiver participants' rights regarding language access and the Contractor's obligation to ensure access to alternative communication services where determined appropriate based upon the needs assessment conducted by the Contractor. [22 CCR 98324]

5. Noncompliance with this section may result in suspension or termination of funds and/or termination of this Agreement. [22 CCR 98370]

C. Compliance Monitoring

1. The Contractor shall develop and implement policies and procedures for assessing and monitoring the performance of individuals and entities that provide alternative communication services to non-English and LEP waiver participants. [22 CCR 98310]

2. The Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. [22 CCR 98310]

3. The Contractor shall permit timely access to all records of compliance with this section. Failure to provide access to such records may result in appropriate sanctions. [22 CCR 98314]

D. Notice to Eligible Beneficiaries of Contracted Services

1. The Contractor shall designate an employee to whom initial complaints or inquiries regarding national origin can be directed. [22 CCR 98325]

2. The Contractor shall make available to ultimate beneficiaries of contracted services and programs information regarding CDA's procedure for filing a complaint and other information regarding the provisions of Cal. Gov. Code § 11135 et seq. [22 CCR 98326]

3. The Contractor shall notify CDA immediately of a complaint alleging discrimination based upon a violation of State or federal law. [2 CCR 11162, 22 CCR 98310, 98340]

ARTICLE I. SUBCONTRACTING PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

A. Contractor shall ensure that all subcontractors of Waiver Services complete a CDA-approved Vendor Application.

B. Contractor shall ensure that the subcontractor's selection process is based upon equitable criteria that provides for adequate publicity, screens out unqualified subcontractors who would not be able to provide the needed services and provide for awards to the lowest responsible and responsive bidder(s) as defined in California State Contracting Manuals.

C. Subcontracts for Purchased Waiver Services shall consist of standard format language consistent with this Agreement.

D. Subcontracts shall require all subcontractors to report immediately in writing to the Contractor any incidents of fraud or abuse to waiver participants, in the delivery of services, and/or in subcontractors' operations.

E. Contractor shall require all subcontractors to comply with the Health Insurance Portability and Accountability Act (HIPAA) Business Associate requirements in Exhibit F, as it appropriately relates to services rendered.

F. Contractors shall ensure all subcontractors comply with Electronic Visit Verification (EVV) requirements pursuant to federal and state law. The Contractor will provide EVV program monitoring, subcontractor training, ongoing subcontractor technical support, assistance with subcontractor compliance enforcement, and perform follow-up. Contractor will incorporate EVV requirements as part of their respective agreements involving applicable MSSP subcontractors. Updated guidance may be obtained through DHCS, the state department overseeing EVV implementation.

G. The Contractor shall make timely payments to its subcontractors under this Agreement.

ARTICLE II. RECORDS PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

Waiver Participant records are to be kept as long as the case is open and active. Following case termination, waiver participant records will be maintained for a period of seven (7) years following case closure, or for a longer period if deemed necessary by CDA. A longer period of retention may be established by individual sites.

ARTICLE III. PROPERTY PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

A physical inventory of the property must be taken, and the results reconciled with the property records at least once every two (2) years.

ARTICLE IV. AUDIT REQUIREMENT PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

A. Unless prohibited by law, the cost of audits completed in accordance with provisions of Single Audit Act Amendments of 1996, are allowable charges to Federal Awards. The costs may be considered a direct cost, or an allocated indirect cost, as determined in accordance with provisions of applicable OMB cost principal circulars.

B. The Contractor may not charge to federal awards the cost of any audit under the Single Audit Act Amendments of 1996 not conducted in accordance with the Act.

C. CDA and DHCS shall have access to all audit reports of Contractors and have the option to perform audits and/or additional work, as needed.

D. All audits shall be performed in accordance with and address all issues contained in any federal OMB Compliance Supplement that applies to this program.

E. The Contractor shall include in its contract with an independent auditor a clause permitting access by the State to the work papers of the independent auditor.

F. Audits to be performed shall be, minimally, financial and compliance audits, and may include economy and efficiency and/or program results audits.

G. The Contractor shall cooperate with, and participate in, any further audits which may be required by DHCS.

H. The Contractor agrees that CDA, DHCS, the Department of General Services, the California State Auditor, or their designated representative shall, at all times, have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to maintain such records for possible audit for a minimum of three (3) years after final payment unless a longer period of records retention is required and until after CDA's Audits and Risk Management Branch has completed an audit. The Contractor agrees to provide CDA or its delegate with any relevant information requested and shall permit the awarding agency or its delegate access to its premises, upon reasonable notice, during normal business hours for the purpose of interviewing employees and inspecting and copying such books, records, accounts, and other material that may be relevant to a matter under investigation for the purpose of determining compliance with Government Code, Section 8546.7 et seq. Further, the Contractor agrees to include a similar right of CDA and DHCS to audit records and interview staff in any subcontract related to performance of this Agreement. [Cal. Gov. Code § 8546.7, Cal. Pub. Con. Code 10115 et seq.], [CCR Title 2, Section 1896]

I. The Catalog of Federal Domestic Assistance Number is 93.778, Grantor Medical Assistance Program.

ARTICLE V. TERMINATION OBLIGATIONS SPECIFIC TO THIS MSSP AGREEMENT

A. After CDA's Notice of Termination or the Contractor's Notice of Intent to Terminate (pursuant to Exhibit D, Article XII of this Agreement) and except as directed by CDA, the Contractor shall immediately proceed with the following obligations, as applicable, regardless of any delay in determining or adjusting any funds due under this clause.

The Contractor shall:

1. Take immediate steps to ensure the health and safety of waiver participants in MSSP managed by the Contractor. Contractor agrees to refer MSSP waiver participants to other local resources.

2. Maintain staff to provide services to waiver participants during the course of waiver participant transition.

3. Deliver updated waiver participant records to the subsequent MSSP contractor or as directed by CDA.

4. With assistance from CDA, develop a written Transition Plan to locate alternative services for each waiver participant through another MSSP site or community agency in accordance with this Agreement.

5. Be responsible for providing all necessary waiver participant services until termination or expiration of the Contract and shall remain liable for the processing and payment of invoices and statements for covered services provided to waiver participants prior to such expiration or termination.

6. Submit a full accounting and closeout of the Contractor's existing budget.

7. Place no further subcontracts/vendor agreements for materials, or services, except as necessary to complete the continued portion of the Contract.

8. Settle all outstanding liabilities and termination settlement proposals arising from the termination of subcontracts/vendor agreements (the approval or ratification of which will be final for purposes of this clause).

9. Submit a Transition Plan as specified in Article VII of this Exhibit.

ARTICLE VI. INFORMATION INTEGRITY AND SECURITY PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

A. Contractor acknowledges that it has been provided a copy of the Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement between CDA and DHCS ("Exhibit F"). Contractor, and its subcontractors/vendors, agrees that it must meet the requirements imposed on CDA, and all applicable provisions of HIPAA,

ARTICLE VI. INFORMATION INTEGRITY AND SECURITY PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

the HITECH Act, the HIPAA regulations, and the Final Omnibus Rule, including the requirement to implement reasonable and appropriate administrative, physical, and

B. technical safeguards to protect Protected Health Information (PHI) and Personal Information (PI), as specified in Exhibit F.

C. Contractor, and its subcontractors/vendors, agrees that any security incidents or breaches of unsecured PHI or PI will be immediately reported to CDA as described in CDA's Security Incident Reporting Procedures and to DHCS in the manner described in Exhibit F.

ARTICLE VII. TRANSITION PLANS SPECIFIC TO THIS MSSP AGREEMENT

A. The Contractor shall submit a transition plan to CDA within fifteen (15) days of delivery of the written Notice to Terminate the Contract (pursuant to Exhibit D, Article XII of this Agreement). The Transition Plan must be approved by CDA and shall, at a minimum, include the following:

1. A current waiver participant count and identifying waiver participant information upon request.

2. A description of how waiver participants will be notified about the change in their MSSP provider.

3. A plan to communicate with other MSSP sites, local agencies and advocacy organizations that can assist in locating alternative services for MSSP waiver participants.

4. A plan to inform community referral sources of the pending termination of this MSSP contract and what alternatives, if any, exist for future referrals.

5. A plan to evaluate the health and safety of waiver participants in order to assure appropriate placement.

6. A plan to transfer confidential waiver participant records to a new contractor or care management agency.

7. A plan to maintain adequate staff to provide continued care to MSSP waiver participants through the term of the Contract.

8. A full inventory and plan to dispose or, transfer, or return to CDA all property purchased during the entire operation of the Contract.

ARTICLE VII. TRANSITION PLANS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

9. Additional information as necessary to affect a safe transition of waiver participants to other MSSP or community care management programs.

B. The Contractor shall implement the Transition Plan as approved by CDA. CDA will monitor the Contractor's progress in carrying out all elements of the Transition Plan.

C. If the Contractor fails to provide and implement a transition plan as required by Section A of this Article, the Contractor agrees to implement a transition plan submitted by CDA to the Contractor following the Contractor's Notice of Termination.

D. Phase-out Requirements for this Agreement:

1. Consist of the processing, payment, and monetary reconciliation necessary to pay claims for Waiver Services.

2. Consist of the resolution of all financial and reporting obligations of the Contractor. The Contractor shall remain liable for the processing and payment of invoices and other claims for payment for Waived Services and other services provided to waiver participants pursuant to this Contract prior to the expiration or termination. The Contractor shall submit to CDA all reports required.

3. Require all data and information provided by the Contractor to CDA to be accompanied by a letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials supplied.

ARTICLE VIII. REPORTING REQUIREMENTS SPECIFIC TO THIS MSSP AGREEMENT

A. The Contractor shall submit to the State written reports, on a format prescribed by the State, as follows:

1. Quarterly Status Reports

a. Reports are due no later than the 30th of the month, following the close of the quarter unless otherwise specified by CDA.

b. Reports are a snapshot of each quarter and shall include an overview of significant developments during the report period, identified problems, and solutions. The report narrative should be concise and informative. The subject areas to be addressed are:

- Care Management Staffing – Including the Full Time Equivalent (FTEs) for each position and staffing ratio. Also including staff exemptions and self-certification of staff meeting program requirements

ARTICLE VIII. REPORTING REQUIREMENTS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

- Care Management Activity – Including staff turnover, training, quality assurance, waiver participant grievances and Fair Hearings, Critical Incident reporting, internal/external program reviews and corrective action plans, waiver participant satisfaction surveys, policy changes, and contract compliance regarding contracted caseload

- Management Information System – Problems/issues with the Medi-Cal fiscal intermediary billing system and Medi-Cal fiscal intermediary technical support

- Monthly active waiver participant count

- Staff Roster

- Self-Certified Training

- Wait List – Including the number of potential MSSP participants waiting for enrollment

- Critical Incident Reporting – Report is used for the entire fiscal year and is submitted quarterly for review by CDA. The report shall include all critical incidents and the status should be updated in each quarter for any previously listed incidents. The comments section should be concise, but informative, and provide detail of the incident that occurred with actions or interventions placed with corresponding dates.

- Fiscal Reporting – Expenditure data by budget category and receivables by budget category

2. Ad Hoc Reports

The Contractor shall submit Ad Hoc Reports as may be required from time to time by CDA. Typical subject areas may include, but are not limited to:

a. General site operations
b. Facility and equipment
c. Emergency care and response
d. Availability of care
e. Waiver participant satisfaction
f. MIS operations
g. Administrative procedures
h. Database

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ARTICLE VIII. REPORTING REQUIREMENTS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

i. Possible noncompliance with this Agreement
j. Fiscal year closeout

3. Fiscal Closeout Reports

As part of the closeout procedures for this contract, the Contractor shall submit a closeout package which must include the following documents:

a. Final Accounting Reconciliation
b. Closeout Budget
c. Fiscal Summary Report for the State

CDA will transmit specific closeout instructions, including the Closeout Report due dates.

4. Monthly active waiver participant count

Reports are due on the 5th working day of each month, unless otherwise specified by CDA.

B. The Contractor, at its discretion, may at any time prepare and submit reports and correspondence to CDA summarizing problems and concerns.

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's 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 shall 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.

7.2 **Nondisclosure.** Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

8. Compliance with Other Applicable Law

8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 19. 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, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

9.1 Safeguards and Security.

9.1.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 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 shall be based on applicable Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.1.2 Business Associate shall, at a minimum, utilize a National Institute of Standards and Technology Special Publication (NIST SP) 800-53 compliant security framework when selecting and implementing its security controls and shall maintain continuous compliance with NIST SP 800-53 as it may be updated from time to time. The current version of NIST SP 800-53, Revision 5, is available online at https://csrc.nist.gov/publications/detail/sp/800-53/rev-5/final; updates will be available online at https://csrc.nist.gov/publications/sp800.

9.1.3 Business Associate shall employ FIPS 140-3 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 140-3 validation can be determined online at https://csrc.nist.gov/projects/cryptographic-module-validation-program/validated-modules/search. In addition, Business Associate shall maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information.

9.1.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.1.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

9.1.6 Business Associate shall 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.

9.1.7 Remote access to PHI from outside the continental United States, inclusive of remote access to PHI by Business Associate's support staff in identified support centers, is prohibited.

9.1.8 Business Associate shall only store PHI in a data center physically located within the continental United States.

9.2 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree 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 shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. **Access to PHI.** Business Associate shall make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate shall 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 shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. **Collaboration.** The parties shall collaborate as appropriate and necessary to ensure compliance with this Agreement, including but not limited to Sections 11 – 13 of this Agreement. The parties acknowledge and agree that neither party intends that this Agreement shall create obligations and/or liabilities that do not otherwise exist as appropriate based on the nature of the work performed and applicable law.

15. **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.

16. **Access to Practices, Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.

17. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate shall 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 shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall 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.

18. **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 shall 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.

19. Breaches and Security Incidents. Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

19.1 Notice to DHCS.

19.1.1 Business Associate shall notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification shall be provided via the DHCS Incident Reporting Portal upon discovery of the breach. If Business Associate is unable to provide notification via the DHCS Incident Reporting Portal, then Business Associate shall provide notice by email or telephone to DHCS.

19.1.2 Business Associate shall notify DHCS **within 24** hours via the online DHCS Incident Reporting Portal (or by email or telephone if Business Associate is unable to use the DHCS Incident Reporting Portal) of the discovery of the following, unless attributable to a treatment provider that is not acting as a business associate of Business Associate:

19.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

19.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

19.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

19.1.2.4 Potential loss of confidential information affecting this Agreement.

19.1.3 Notice submitted to the DHCS Incident Reporting Portal will be sent to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office. If providing notice to DHCS via email, use the DHCS contact information at Section 19.6 below (collectively, “DHCS Contacts”).

Notice shall be made using the DHCS Incident Reporting Portal via the link on the DHCS Data Privacy Website online at

https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx

Notice via email shall be made using the current DHCS “Privacy Incident Reporting Form” and shall include all information known at the time the incident is reported. The form is available online at

https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Privacy-Incident-Report-PIR.pdf

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

19.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

19.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

19.2 Investigation. Business Associate shall immediately investigate such security incident or breach.

19.3 **Complete Report**. Business Associate shall provide a complete report of the investigation to DHCS within ten (10) working days of the discovery of the security incident or breach. This complete report must include any applicable additional information not included in the initial submission. The complete report shall 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 shall 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 additional information, Business Associate shall make reasonable efforts to provide DHCS with such information. 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.

19.3.1 If Business Associate does not submit a complete report within the ten (10) working day timeframe, Business Associate shall request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the complete report.

19.4 **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 shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

19.5 **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.

19.6 **DHCS Contact Information**. To contact the above referenced DHCS staff, the Contractor shall 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: Data Privacy Unit 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 Department of Health Care Services P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

20. 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.

21. Audits, Inspection and Enforcement

21.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall 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.

21.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

22. Termination

22.1 **Termination for Cause**. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

22.1.1 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

22.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

22.2 **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.

23. Miscellaneous Provisions

23.1 **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.

23.2. **Amendment**.

23.2.1 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.

23.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 23.2.1 shall constitute a material violation of this Agreement.

23.3 **Assistance in Litigation or Administrative Proceedings**. Business Associate shall 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.

23.4 **No Third-Party Beneficiaries**. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

23.5 **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.

23.6 **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 A, Attachment 1
General Information

1. The Contractor agrees to provide to the California Department of Aging (CDA) the services described herein Agreement number MS-2526-41.

2. The number of client slots per month shall be 568.

3. The services shall be performed in the catchment area zip codes listed in Exhibit G.

4. The services shall be provided as needed.

5. The project representatives during the term of this agreement will be:

State Agency: California Department of Aging	Contractor: ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
Name: MSSP Operations Manager	Name: Evelyn Rounds
Section/Unit: MSSP	Section/Unit: Multipurpose Senior Services Program
Address: 2880 Gateway Oaks Dr., Ste 200 Sacramento, CA 95834	Address: 505 City Parkway West Orange, CA 92868
Phone: (916) 419-7561	Phone: (714) 246-8773
Email: MSSPservice@aging.ca.gov	Email: erounds@caloptima.org

Direct all contract document inquiries to:

State Agency: California Department of Aging	Contractor: ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
Section/Unit: Subvention and Local Assistance Contracts Section	Section/Unit: Multipurpose Senior Services Program
Attention: Andrew Reel, Analyst	Attention: Evelyn Rounds, Site Director
Address: 2880 Gateway Oaks Dr., Ste 200 Sacramento, CA 95834	Address: 505 City Parkway West Orange, CA 92868
Phone: (916) 272-0469	Phone: (714) 246-8773
Email: BMBSubvention@aging.ca.gov	Email: erounds@caloptima.org

The parties may change their representatives upon providing ten days written notice to the other party. Said changes do not require an amendment to this agreement.

CALIFORNIA DEPARTMENT OF AGING
Multipurpose Senior Services Program
2880 Gateway Oaks Drive, Suite 200
Sacramento, CA 95833
www.aging.ca.gov
TEL 916-419-7500
FAX 916-928-2267
TTY1-800-735-2929

March 24, 2025

Ms. Evelyn Rounds, Site Director
Multipurpose Senior Services Program -41
505 City Parkway West
Orange, California 92868

Dear Ms. Rounds,

The California Department of Aging, Multipurpose Senior Services Program (MSSP) Bureau has completed a review of your MSSP site budget for Fiscal Year (FY) 2025-2026. As a result of our review, the Department approves the projected expenditure of MSSP funds by budget category.

Enclosed is a copy of the signed and approved budget for your records. The original will be kept on file at the Department. If you have any questions, please contact your assigned program analyst.

Sincerely,



Kimberly Bymers, Operations Manager
Multipurpose Senior Services Program Bureau
California Department of Aging

Enclosure

cc: Jeff Mercer, Program Analyst
Multipurpose Senior Services Program
California Department of Aging

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Site Name	41 - Orange County Health Authority (dba CalOptima)	Funded Slots	568	Date Submitted to CDA-MSSP	4-Mar-25

Fiscal Year 2025-26

A. Care Management

Line #	Position Title	Last Name	Base Salary	Salary Adjustment	FTE	Adjusted Salary
1	Nurse Care Manager	Baylis	$132,432	0.000%	1.000	$132,432
2	Nurse Care Manager	Dang	$131,165	0.000%	1.000	$131,165
3	Nurse Care Manager	Holton	$133,067	0.000%	1.000	$133,067
4	Nurse Care Manager	Nguyen K.	$112,685	0.000%	1.000	$112,685
5	Nurse Care Manager	Nguyen T.	$133,067	0.000%	1.000	$133,067
6	Nurse Care Manager	St. Lawrence	$128,047	0.000%	1.000	$128,047
7	Nurse Care Manager	Vong	$116,548	0.000%	1.000	$116,548
8	Social Work Care Manager	Anderson	$99,624	0.000%	1.000	$99,624
9	Social Work Care Manager	Benedik	$89,432	0.000%	1.000	$89,432
10	Social Work Care Manager	Choi	$88,982	0.000%	1.000	$88,982
11	Social Work Care Manager	Gil	$85,719	0.000%	1.000	$85,719
12	Social Work Care Manager	Nguyen	$98,047	0.000%	1.000	$98,047
13	Social Work Care Manager	Pratt	$108,824	0.000%	1.000	$108,824
14	Social Work Care Manager	Santoyo	$98,613	0.000%	1.000	$98,613
15	Social Work Care Manager	TBH	$88,419	0.000%	1.000	$88,419
16			$0	0.000%	0.000	$0
17			$0	0.000%	0.000	$0
18			$0	0.000%	0.000	$0
19			$0	0.000%	0.000	$0
20			$0	0.000%	0.000	$0
21			$0	0.000%	0.000	$0
22			$0	0.000%	0.000	$0
23			$0	0.000%	0.000	$0
24			$0	0.000%	0.000	$0
25			$0	0.000%	0.000	$0
26					Subtotal Care Management Salaries	$1,644,672
27	Total Care Management (CM) FTE	15.00			Care Management Benefits	$0
28	Ratio	37.9				
29	**Total Care Management**			% Budget	54%	$1,644,672

B. Care Management Support/Administration

Salaries

Line #	Position Title	Last Name	Base Salary	Salary Adjustment	FTE	Adjusted Salary
30	Accounting Specialist	Vu	$90,250	0.000%	0.500	$45,125
31	Site Director	Rounds	$175,827	0.000%	1.000	$175,827
32	Care Manager Aide	Castaneda	$64,702	0.000%	1.000	$64,702
33	Care Manager Aide	Diaz De Leon	$63,605	0.000%	1.000	$63,605
34	Care Manager Aide	Garcia	$58,178	0.000%	1.000	$58,178
35	Care Manager Aide	Pham	$55,113	0.000%	1.000	$55,113
36	Accounting Supervisor	Lopez	$113,638	0.000%	0.250	$28,409
37	Supervising Care Manager	Dinh	$109,896	0.000%	1.000	$109,896
38	Supervising Care Manager	Rivera	$126,444	0.000%	1.000	$126,444
39	Supervising Care Manager	Young	$125,616	0.000%	1.000	$125,616
40			$0	0.000%	0.000	$0
41			$0	0.000%	0.000	$0
42			$0	0.000%	0.000	$0
43			$0	0.000%	0.000	$0
44			$0	0.000%	0.000	$0
45			$0	0.000%	0.000	$0
46			$0	0.000%	0.000	$0
47			$0	0.000%	0.000	$0
48					Subtotal CMS/Administration Salaries	$852,915
49					CMS/Administration Benefits	$0
50	Total CMS/Administration FTE	8.75				
51					Total CMS/Administration Salaries	$852,915

Operating Costs

52	Consultation, Professional Services			$68,000
53	Facility, Rent & Operations			$0
54	Equipment Cost equal to or greater than $5,000 per Unit (Any Computing Equipment regardless of Cost)			$0
55	Equipment, Maintenance & Rental Costs; Supplies			$0
56	Travel (In & Out of State)			$14,500
57	Training without Associated Travel Costs			$0
58	Subscriptions, Membership Dues			$10,000
59	Insurance			$0
60	Communication, Postage, Internet			$19,000
61				$0
62				$0
63	Indirect Costs (Indirect Costs/Base) - 15% maximum		2%	$37,634
64	Base = Salaries & Benefits	$2,497,587		
65				$0
66				$0
67			Total CMS/Administration Operating Costs	$149,134
68	**Total CMS/Admin**	% Budget	33%	$1,002,049

C. Waived Services

69	**Total Waived Services**	% Budget	13%	$395,487

D. Total Budget Amounts

70	**Fiscal Year Total Allocation**		$3,042,208

By completing Part I, I understand that this is an electronic signature and by checking the box I certify that all the provided information is believed to be accurate, reliable and complete to the best of my knowledge and ability to confirm it.

Full Name	Title	Date	Check box to indicate agreement with information provided in report.
Evelyn Rounds	Site Director	March 12, 2025	☑

For CDA Use Only.

Approved by:

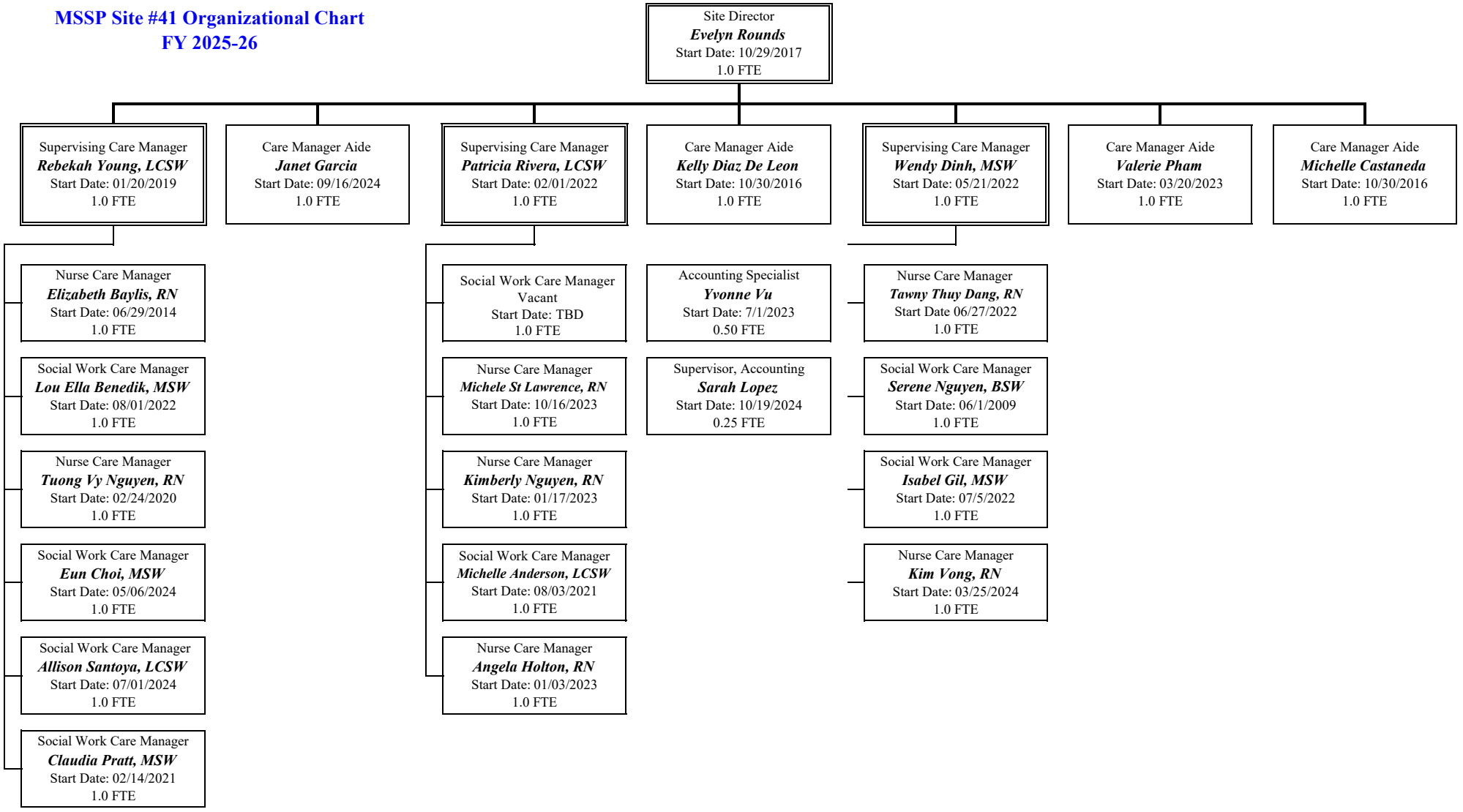
Poonam Deo — Analyst Signature

3/19/2025 — Date

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MSSP Site #41 Organizational Chart
FY 2025-26



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Orange County Health Authority, dba CalOptima

Aliso Viejo	92653, 92656, 92698
Anaheim	92801- 92809, 92812, 92814 - 92817, 92825, 92850, 92899
Anaheim Hills	92807, 92808, 92809, 92817
Atwood	92811
Balboa	92661
Balboa Island	92662
Brea	92821, 92822, 92823
Buena Park	90620, 90621, 90622, 90623, 90624
Capistrano Beach	92624
Corona del Mar	92625
Costa Mesa	92626, 92627, 92628
Coto de Caza	92679
Cowan Heights	92705
Cypress	90630
Dana Point	92624, 92629
Dove Canyon	92679
East Lake	92686
East Tustin	92780
El Modena	92869
El Toro	92609, 92610, 92630
Emerald Bay	92718
Foothill Ranch	92610
Fountain Valley	92708, 92728
Fullerton	92831, 92832, 92833, 92834, 92835, 92836, 92837, 92838
Garden Grove	92840, 92841, 92842, 92843, 92844, 92845, 92846
Huntington Beach	92605, 92615, 92646, 92647, 92648, 92649
Irvine	92602 - 92604, 92606, 92612, 92614, 92616, 92618 - 92620, 92623, 92650, 92697, 92709, 92710
Ladera	92692
Ladera Ranch	92694
Laguna Beach	92607, 92637, 92651, 92652, 92653, 92654, 92656, 92677, 92698
Laguna Hills	92637, 92653, 92654, 92656
Laguna Niguel	92607, 92677, 92653, 92654
La Habra	90631, 90632, 90633
La Habra Heights	90631
Lake Forest	92609, 92630
La Plama	90623
Las Flores	92688
Lemon Heights	92705
Lido Isle	92663
Los Alamitos	90720, 90721
Midway City	92655
Mission Viejo	92675, 92690, 92691, 92692, 92694
Modjeska	92676
Monarch Beach	92629

Orange County Health Authority, dba CalOptima

Newport Beach	92657, 92658, 92659, 92660, 92661, 92662, 92663
Newport Center	92660
Newport Coast	92657
Northwood	92629
Olinda	92621
Olive	92665
Orange	92856, 92857, 92859, 92861- 92869
Orange Park Acres	92869
Placentia	92870, 92871
Portola Hills	92679
Rancho Santa Margarita	92688
Red Hill	92705
Rossmoor	90720
San Clemente	92672, 92673, 92674
Santa Ana	92701- 92708, 92711, 92712, 92725, 92728, 92735, 92799
Santa Ana Heights	92707
San Juan Capistrano	92675, 92690, 92691, 92692, 92693, 92694
San Juan Hot Springs	92675
Seal Beach	90740
Silverado	92676
South Laguna	92651
Stanton	90680
Sunset Beach	90742
Surfside	90743
Three Acres Bay	92677
Trabuco Canyon	92678, 92679, 92688
Turtle Rock	92612
Tustin	92780, 92781, 92782
Villa Park	92861, 92867
Westminster	92683, 92684, 92685
Woodbridge	92714
Yorba Linda	92885, 92886, 92887

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contacts

Michael Hunn, Chief Executive Officer, (714) 246-8570
Steve Eckberg, Chief Human Resources Officer, (657) 328-9053

Recommended Actions

Adopt Resolution No. 25-0605-02 approving updated CalOptima Health policies:

1. GA.8012: Conflicts of Interest and Attachment C;
2. GA.8020: 9/80 Work Schedule;
3. GA.8032: Employee Dress Code;
4. GA.8042: Supplemental Compensation;
5. GA.8047: Reduction in Force; and
6. GA.8062: Social Media Conduct.

Background

Near CalOptima Health's inception, the Board of Directors (Board) delegated authority to the Chief Executive Officer to develop and implement employee policies and procedures and to amend them as appropriate from time to time, subject to bi-annual updates to the Board. CalOptima Health's Bylaws require that the Board adopt by resolution, and from time to time amend, procedures, practices, and policies for, among other things, hiring employees and managing personnel.

Discussion

Staff has included the list of revised policies for Board approval and a summary of changes for the updated policies below.

GA.8012: Conflicts of Interest: This policy establishes guidelines and standards for CalOptima Health Employees to avoid conflicts of interest and incompatible outside activities. Employees are required to submit Attachment C to Human Resources for determination of any outside interest(s) they may have which could be perceived as a potential conflict of interest with their employment with CalOptima Health.

Policy Section	Proposed Change	Rationale	Impact
II.K	Add new section K, "CalOptima Health and each of its Subcontractors and Downstream Subcontractors, must notify their DHCS Contract Manager within ten (10) working days of when they become aware of any potential,	Complies with DHCS contract Exhibit H Conflict of Interest Avoidance Requirements.	Provides clarity and transparency on the reporting of potential conflicts of interest.

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	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."		
III.A.4	Add to section, "Notify Regulatory Affairs and Compliance (RAC) of any potential, suspected, or actual conflict of interest."	Complies with DHCS contract Exhibit H Conflict of Interest Avoidance Requirements.	Provides clarity and transparency on the reporting of potential conflicts of interest.
III.A.4.a	Add new subsection, "Provide RAC with a description of the relationship and a conflict avoidance plan to avoid, neutralize, and/or mitigate the potential, suspected, and/or actual conflict of interest."	Complies with DHCS contract Exhibit H Conflict of Interest Avoidance Requirements.	Provides clarity and transparency on the reporting of potential conflicts of interest.
III.B.8.c	Add new subsection, "Following the conflict of interest avoidance plan."	Complies with DHCS contract Exhibit H Conflict of Interest Avoidance Requirements.	Provides clarity and transparency on the reporting of potential conflicts of interest.
Attachment C	Revise "Place of Employment" to "Name of Employer or Activity."	Directs the requestor to document the name of the employer or non-employment activities.	Provides clarity on how to complete this field.
Attachment C	Revise "Compliance" review/approval to "if necessary" and switched placement of the Compliance approval with Human Resources.	Clarifies the review order and approval roles within the form.	Provides clarity and consistency in the completion of the form.

GA.8020: 9/80 Work Schedule: This policy outlines how CalOptima Health will administer an alternate workweek schedule, commonly referred to as a 9/80 Work Schedule.

Policy Section	Proposed Change	Rationale	Impact
Throughout Policy	Revises grammatical word and sentence structure.	Communicates with clear and concise language.	Provides clarity and accuracy of the information.

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II.C.	Add to 9/80 schedule eligibility "Management will determine eligible positions based on business needs and member service expectations" to replace pre-existing eligibility criteria. Position eligibility is described in Reference E to the policy.	Provides management with enhanced guidance on employee eligibility to participate in a 9/80 alternative work schedule.	Provides clarity that business needs determine the use and availability of 9/80 alternate work schedules.
II.C.	Revise language that employees on a 9/80 schedule who are not meeting performance and behavior standards "may be returned to a standard 5/40 schedule" until performance improves.	Aligns policy to GA.8022 Performance and Behavior Standards and clarifies that a 9/80 work schedule is not an entitlement.	Provides clarity and consistency in the use of 9/80 work schedules.
II.D.	Delete "Approval" Section.	Adds approval procedure to policy Reference E.	Organizes procedural and administrative guidance to Reference E.
II.E.	Delete "Transition to the 9/80 Work Schedule" Section.	Adds 9/80 Work Schedule Transition to policy Reference E.	Organizes procedural and administrative guidance to Reference E.
II.F.	Delete "Hours of Work" Section.	Adds Hours of Work to policy Reference E.	Organizes procedural and administrative guidance to Reference E.
II.F.	Replace "compelled" with "required".	More accurately describes that business needs determine employee work schedules and the availability of 9/80.	Provides clarity that business needs determine the use and availability of 9/80 alternate work schedules.
III. Procedure	Delete Procedure table.	Adds Procedure steps to policy Reference E.	Organizes procedural and administrative guidance to Reference E.
IV. References (E)	Add 9/80 Work Schedule Guidelines as Reference E to the policy.	Provides supplemental information regarding the administration of the 9/80 Work Schedule.	Organizes procedural and administrative guidance to Reference E.

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GA.8032: Employee Dress Code: This policy establishes guidelines for appropriate workplace attire and grooming for all CalOptima Health employees, limited term workers, volunteers, and contractors including those working in the field and remote locations.

Policy Section	Proposed Change	Rationale	Impact
Throughout Policy	Revise grammar and sentence structure.	Communicates with clear and concise language.	Provides clarity and accuracy of the information.
I. Purpose	Add "limited term workers, volunteers, and contractors" to who this policy applies to.	Applies the Employee Dress Code policy to all workers who may represent CalOptima Health.	Provides clarity and accuracy on who is subject to the Employee Dress Code policy.
II.C	Delete Section C, "All employees are required to sign the Dress Code Acknowledgement Form upon hire."	Removes requirement from the new hire onboarding procedure as the year-round standard attire is casual.	Removes a form from new hire orientation which improves onboarding efficiency.
III. Procedure – Human Resources	Add that the Employee Dress Code policy is provided to all employees "during the onboarding process and review during the new hire orientation."	Enhances orientation with a discussion on policy and appropriate attire for all new hires.	Provides information and transparency during orientation.
V. References	Remove the Dress Code Acknowledgment Form.	Removes requirement from the new hire onboarding procedure as the year-round standard attire is casual.	Removes a form from new hire orientation which improves efficiency of onboarding.

GA.8042: Supplemental Compensation: This policy establishes general guidelines concerning the use of supplemental compensation above regular base pay to compensate for business needs and to identify items to be reported to CalPERS as "Special Compensation."

Policy Section	Proposed Change	Rationale	Impact
Throughout Policy	Revises grammar and formatting.	Communicates with clear and concise language.	Provides clarity and accuracy of the information.
II. A.5	Remove "Executive Incentive Program/Bonus Pay; and"	Aligns with Title 2, California Code of Regulations Section 571	Clarifies that this incentive is special compensation not

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			reportable to CalPERS.
II.C. Holiday Premium Pay	Remove "full time" from eligibility criteria.	Removes limitation that only full time employees are eligible for Holiday Premium Pay.	Allows part-time employees to participate in Holiday Premium Pay.
II.C. Holiday Premium Pay	Add "for employees who are normally required to work on an approved holiday because they work in positions that require scheduled staffing without regard to holidays."	Aligns with Title 2, California Code of Regulations Section 571.	Adds clarity and transparency as to when Holiday Premium Pay is treated as special compensation.
II.D. Bilingual Pay	Revise Bilingual Pay table to include Rate Per Pay Period (Part-Time) as $30.00 and $20.00. Removes "in the job description" from the Proficiency column.	Allows part-time employees to participate in Bilingual Pay. Clarifies that management has discretion to determine when bilingual proficiency is required of a position based on business need.	Adds clarity and transparency to Bilingual Pay calculation for part-time employees.
II.G. Call Back and On Call	Revise table definition of Call Back to "Call Back – Employees must physically return to the worksite after their regular shift has ended and they have physically left the workplace within one (1) hour when requested by a Supervisor. A Supervisor may assign employees other work until the minimum of four (4) hour has elapsed."	Adds more context and instruction to staff on the application and eligibility of Call Back pay.	Provides clarity and transparency on the conditional use of Call Back pay.
II.G. Call Back and On Call	Revise table definition to remove "Medical Case Managers (RN or LVN and" from the list of eligible positions.	Medical Case Managers are no longer -exempt positions, so this provision does not apply to them.	Clarifies eligible positions.
II.G. Call Back and On Call	Revise eligibility for Call Back and On Call to "All" non-exempt "positions" and removes "employees".	Adds clarity that Call Back and On Call pay eligibility is for the entirety of the agency's non-exempt workforce rather than a subset.	Provides clarity and consistency on eligibility.

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II.G. Call Back and On Call	Add "waiting" and "on call working and" to On Call table for non-exempt Rates.	Creates further distinction between On Call and Call Back pay usage.	Provides clarity and transparency on calculation of pay.
II. H. Commuter Allowance	Add "For new hires, the Commuter Allowance begins with the first pay period of their employment. For changes to the telework status, any resulting change to the Commuter Allowance begins the first Full Pay Period…".	Provides clarity on when the Commuter Allowance starts.	Provides clarity and transparency on calculation of pay.
II.I. Internet Stipend	Add "and eighteen dollars seventy-five cents ($18.75) to part-time employees."	Provides the stipend rate for eligible part-time employees.	Provides clarity and transparency on calculation of pay.
II.K. Executive Incentive Program	Revise subsection title Executive Incentive "Program" to "Plan"; remove "compensation as described in this Policy"; remove "the incentive compensation is considered bonus pay pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation for CalPERS Classic Members"; and add "Detailed elements of this program are available in the CalOptima Health Executive Incentive Plan Guidelines."	Revises language to align with Title 2, California Code of Regulations Section 571. Adds reference to supplemental guidelines in the policy.	Clarifies that this incentive is special compensation not reportable to CalPERS.
II.L.1. OneCare Program	Add "Director I, Sales and Marketing" and "OneCare Community Partner Inside Sales."	Updates list of positions eligible to participate in OneCare Program's sales incentive.	Provides clarity and transparency on calculation of sales incentive pay.
II.T. Supplemental Retirement Benefit	Add "401(a) tax-qualified"; remove "plan administered by the Public Agency Retirement System (PARS)"; and add "Government Code sections 7522.72 and 7522.74 require the forfeiture of all accrued rights and benefits in any public retirement system by any public employee convicted of any job-related felony, as of the earliest date of the crime."	PARS contract terminated Jan 1, 2025, and services transition to Empower.	Provides transparency on PARS benefit eligibility.

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III.C. Bilingual Pay	Remove "bilingual" and replaces it with "language fluency" that is "required" as part of their job duties.	Provides clarity as language fluency speaks to ability level.	Provides clarity and transparency on the administration of Bilingual Pay
III.C. Bilingual Pay	Add "For new hires, the Bilingual Pay begins with the first full pay period of their employment. Changes to Bilingual Pay will occur at the start of a pay period. Bilingual pay shall not be prorated. Temporary and/or interim assignments will not impact bilingual pay."	Provides procedural guidance on the payroll processing of Bilingual Pay.	Provides clarity and transparency on pay calculation.
III.E.1. Night Shift	Remove "consecutive" from "7 consecutive hours" worked.	Breaks and scheduling changes may occur that stop the hours from being worked consecutively though the 7 hours are within the night shift period.	Provides clarity and transparency on Night Shift eligibility and calculation.
III.J. Incentive Compensation	Revise section title "Incentive Compensation" to "Executive Incentive Plan."	Adds specificity that this plan pertains to executive level positions.	For clarity and consistency.
III.J.2-3 Incentive Compensation Subsections	Remove subsections 2 and 3.	Administration of the Executive Incentive Plan are moved to the Guidelines in Reference N.	For clarity and consistency.
III.K.2.a. OneCare	Add "Director I, Sales and Marketing" and "OneCare Community Partner Inside Sales."	Updates list of positions eligible to participate in OneCare Program's sales incentive.	Provides clarity and transparency on calculation of sales incentive pay,
III.P. Work Life Balance Stipend	Add "To be eligible, employees must be in active status (either working or on a paid LOA) in the pay period that includes May 1 or November 1. Employees on an approved, unpaid LOA when the Work Life Balance Stipend is paid will receive a retroactive payment upon return to active status."	Clarifies payroll processing timing and eligibility for this stipend as it relates to employees on inactive status.	For clarity and consistency.
III.Q. Benefit Income	Add "Benefit Income may be temporarily suspended for employees who are on an approved	Aligns policy GA8042 with policies GA8039, GA8040, and GA8063.	For clarity and consistency

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	Leave of Absence (LOA) without pay in accordance with CalOptima Health Policies GA.8039: Pregnancy Disability Leave of Absence and Related Workplace Accommodations, GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence, GA.8041: Workers' Compensation Program, or GA.8063: Disability Accommodations. However, retroactive payment for Benefit Income will be applied for the period of protected, unpaid leave upon return to active duty."		between HR policies.
III.S. Supplemental Compensation During Leave of Absence	Adds new subsection, "S. Supplemental Compensation During Leave of Absence: An employee on a Continuous LOA is not eligible to receive certain supplemental compensation, such as Bilingual Pay, Night Shift Premium, Call Back or On Call Pay, Active Certified Case Manager (CCM) Pay, Internet Stipend, Commuter Allowance, or Automobile Allowance during their LOA. If applicable, an employee on a Continuous LOA may be eligible for Employer-Paid Member Contribution, Supplemental Retirement Benefit and Benefit Income during any portion of a paid LOA but shall not be eligible if the LOA is unpaid. Executive incentives will be prorated to account for an executive's Personal LOA time period. Executives must be current employees during the pay period the executive incentive is paid for eligibility. Supplemental compensation will resume when the employee returns to an active	Aligns policy GA8042 with GA8037 Leave of Absence policy.	For clarity and consistency between HR policies.

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	status, and may be prorated, where applicable."		
III.T. Proration	Adds, "Proration: For supplemental compensation that is paid per pay period and not based on hourly pay rate (i.e. Bilingual Pay, Active Certified Case Manager, Internet Stipend, Commuter Allowance, Automobile Allowance, and Benefit Income), such compensation will begin the first full pay period after eligibility is established. These items of compensation will be provided only for full pay periods and will not be prorated for a change in eligibility for a portion of the pay period."	Provides guidance on the proration of supplemental pay types for employees who work full or partial pay periods.	For clarity and consistency.
III.U. Supplemental Compensation for Part Time Employees	Add subsection, "P. Supplemental Compensation for Part-Time Employees a. If eligible, regular Part-Time Employees will receive pro-rated supplemental compensation based on their approved work schedule, as reflected in the timekeeping system, for the following: i. Active Certified Case Manager Pay / Educational Incentive ii. Executive Incentive Pay Plan iii. Annual Merit Lump Sum Bonus iv. Automobile Allowance v. Benefit Income b. Exceptions include the following: i. Bilingual Pay, Internet Stipend and Work Life Balance Stipends will be paid in accordance with Section II."	Provides direction on the application of supplemental compensation for part time employees.	For clarity and consistency.
IV. Attachment (s)	Remove Attachments A and B.	Moved Attachments A and B to the Reference section as Reference N and O respectively.	For clarity and consistency.

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V. References	Add reference documents, "I. OneCare Sales and Enrollment Incentive Program Agreement: Community Partner Inside Sales"; "L. OneCare Sales and Enrollment Incentive Program Agreement: Director I, Sales and Marketing"; "N. CalOptima Health Executive Incentive Plan Guidelines"; and "O. Performance Review of Executives Template."	Updated to reflect two additional job titles that need to complete their agreements in order to participate in the OneCare Sales Incentive. Moves two Attachments pertaining to the Executive Incentive Plan to References as Guidelines.	For clarity and consistency on OneCare sales incentive administration.

GA.8047: Reduction in Force: This policy defines how CalOptima Health shall administer a Reduction in Force (RIF) program. A RIF occurs when changing priorities, budgetary constraints, or other business conditions require CalOptima Health to eliminate positions.

Policy Section	Proposed Change	Rationale	Impact
II.B.	Revise "discipline" to "corrective action".	Aligns to policy GA.8022: Performance and Behavior Standards.	Provides accuracy and consistency in corrective action.
II.E.	Revise "disciplinary" to "corrective" action.	Aligns to policy GA.8022: Performance and Behavior Standards.	Provides accuracy and consistency in corrective action.
III.C.	Remove two mentions of "job" from "job position" in this section.	Communicates with clear and concise language.	Provides clarity and accuracy.
III.C.	Add that a transfer or downgrade may be offered "in lieu of layoff".	Clarifies the use of transfers and downgrades as an alternative to a layoff to retain employee.	Provides clarity and accuracy.
III.C.	Add "An employee who downgrades positions under this policy may be assigned to the pay rate nearest to their present pay rate within the pay grade of the position in which they are demoting provided that it does not exceed the pay range maximum of the new position."	Provides management with discretion to minimize pay impacts to affected employees to focus the transition on the employees' roles and to retain institutional knowledge.	Provides consistency and transparency.
III.D.	Adde "The notice will contain the general reason for the layoff and Separation Date."	Provides affected employees with reasonable notice.	Provides consistency and transparency.

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III.D.	Revise "Executive Director of HR" to "Chief Human Resources Officer".	CalOptima Health does not have an Executive Director of HR.	Provides clarity and accuracy.

GA.8062: Social Media Conduct: This policy outlines requirements for CalOptima Health Employee communication in online communities and compliance with legal and regulatory requirements, including laws concerning privacy and confidentiality.

Policy Section	Proposed Change	Rationale	Impact
Throughout Policy	Change the name of social media platform "Twitter" to "X".	Referenced company's name has changed.	Provides clarity and accuracy.
II. E	Delete subsection E.1.	Removes redundancy of defining Online Communities in the policy and again in the glossary.	Provides clarity and accuracy.
III.A.e	Add "political beliefs" to list of types of disparaging social media postings that are prohibited.	Aligns policy to practice.	Provides consistency and transparency.
III.B.1	Add language, "An employee's personal social media communication that impedes performance of the employee's job duties, interferes with the effective functioning of CalOptima's operations, or undermines CalOptima's mission is prohibited."	Provides context on the existence of a nexus between an employee's personal social media use and their CalOptima Health employment.	Provides clarity and transparency.
III.B.1.i	Add reference to CalOptima Health policy GA.5005a: Use of Technology.	Adds GA.5005a to the list of policies employees are expected to adhere to as it relates to social media conduct.	Provides clarity and transparency.
III.B.1.iv	Revise policy GA.8027 title to "Harassment, Discrimination, and Retaliation Prevention."	Changed to current title of policy GA.8027.	Provides accuracy.
V.D	Revise policy GA.8027 title to "Harassment, Discrimination, and Retaliation Prevention".	Changed to current title of policy GA.8027	Provides accuracy.

Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year (FY) 2024-25 and proposed FY 2025-26 Operating Budgets.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Adopt Resolution No. 25-0605-02 Approving Updated CalOptima Health Human Resources Policies
2. Updated CalOptima Health policies:
    a. GA.8012: Conflicts of Interest and Attachment C
    b. GA.8020: 9/80 Work Schedule and Reference E
    c. GA.8032: Employee Dress Code
    d. GA.8042: Supplemental Compensation
    e. GA.8047: Reduction in Force
    f. GA.8062: Social Media Conduct

/s/ Michael Hunn *05/29/2025*
Authorized Signature **Date**

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RESOLUTION NO. 25-0605-02

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

APPROVE UPDATED CALOPTIMA HEALTH HUMAN RESOURCES POLICIES

WHEREAS, Section 13.1 of the CalOptima Health Bylaws provides that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices, and policies for, inter alia, hiring employees, and managing personnel;

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima Health employees at will, to set compensation within the boundaries of the budget limits set by the Board of Directors, to promulgate employee policies and procedures, and to amend said policies and procedures from time to time, subject to annual review by the Board of Directors, or a committee appointed by the Board of Directors for that purpose; and

WHEREAS, staff has revised certain policies and now presents those revised policies to the Board of Directors for approval.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the following updated CalOptima Health Human Resources policies:

a. GA.8012: Conflicts of Interest and Attachment C;
b. GA.8020: 9/80 Work Schedule;
c. GA.8032: Employee Dress Code;
d. GA.8042: Supplemental Compensation;
e. GA.8047: Reduction in Force; and
f. GA.8062: Social Media Conduct.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 5th day of June, 2025.

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AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Isabel Becerra, Chair, CalOptima Health Board of Directors

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

Policy:	GA.8012
Title:	**Conflicts of Interest**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	02/01/2000
Revised Date:	06/05/2025
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250605 BOD Review Only

I. PURPOSE

This policy establishes guidelines and standards for CalOptima Health Employees to avoid conflicts of interest and incompatible outside activities.

II. POLICY

A. CalOptima Health Employees shall avoid anything that constitutes a real or apparent conflict between their personal interests and the interests of CalOptima Health.

B. CalOptima Health Employees shall avoid conflicts of interest and shall adhere to applicable state and federal laws and regulations, including, but not limited to:

1. California Government Code Section 81000 et seq., requiring all designated employees to comply with the reporting requirements in CalOptima Health's Conflict of Interest Code;

2. California Government Code Section 87100, prohibiting each CalOptima Health Employee from making, participating in making or in any way attempting to use his or her official position to influence a governmental decision in which he or she knows or has reason to know that he or she has a financial interest;

3. California Government Code section 1090, prohibiting each CalOptima Health Employee from being financially interested in any contract made by the employee in his or her official capacity, and prohibiting each employee from being a purchaser at any sale or vendor at any purchase made by him or her in his or her official capacity.

4. California Government Code section 1126, which prohibits each CalOptima Health Employee from engaging in any employment, activity, or enterprise for compensation which is inconsistent, incompatible, in conflict with, or inimical to his or her duties as a local agency officer or employee or with the duties, functions, or responsibilities of CalOptima Health.

5. Title 42 of the United States Code section 1320-7b(b), prohibiting the knowing and willful offer, payment, solicitation or receipt of incentives or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to induce the

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referral of business reimbursable under the Medi-Cal or Medicare programs or to induce an enrollee to use a particular practitioner, provider or supplier.

6. Title 42 of the Code of Federal Regulations section 460.68 regarding the disclosure and recusal requirement of the governing board for direct or indirect interest in any contract that supplies any administrative or care-related service or materials to PACE.

C. A conflict of interest exists in any situation in which an employee uses his or her position or association with CalOptima Health for personal or financial gain. The following guidelines are used to determine whether a real or apparent conflict of interest would exist.

1. *Avoidance of Unfair Competitive Advantage*. An employee's outside employment, consulting, or other business activity outside CalOptima Health may not influence decisions made by CalOptima Health in such a way as to give unfair competitive advantage to the employee's outside business activity.

2. *Use of Privileged or Official Information*. The use of privileged or official information for personal financial gain while employed with or after separating from employment is a type of conflict of interest and is prohibited. Privileged or official information is information that is known to an employee because of his or her employment with CalOptima Health but is not available to the public. The information covered under this provision includes, but is not limited to, personal health information (PHI), provider rates, personnel records, or proprietary information.

3. *Protection of Information Not Yet in Public Domain*. A CalOptima Health Employee acting as an independent consultant or as an employee of another organization may not use information, skills or knowledge obtained as a result of CalOptima Health employment, that is material or necessary to a current, in-progress, or proposed CalOptima Health project, that is proprietary to CalOptima Health and that is not yet in the public domain.

4. *Noncompetition with CalOptima Health*. An employee's outside employment or consulting activity must not compete with current or proposed CalOptima Health projects, programs or initiatives.

D. CalOptima Health Employees shall not handle member or provider issues, applications, requests, or cases on behalf of CalOptima Health for member(s) of the employee's own family or for personal friends.

E. CalOptima Health Employees shall comply with the Code of Conduct and CalOptima Health Policies AA.1204: Gifts, Honoraria, and Travel Payments and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health. Other than as permitted in CalOptima Health Policies, employees shall not receive gratuity, rebates, kickbacks, accommodation, or other unlawful consideration from any one provider, supplier, vendor, firm, or organization with whom CalOptima Health is currently doing or could potentially do business with. It is the responsibility of the employee to return any gift delivered to them and to notify the Clerk of the Board of such action.

F. CalOptima Health Employees shall be aware of what outside activities, investments, and/or positions may conflict with or detract from their effectiveness in employment with CalOptima Health and shall avoid such conflicts.

G. CalOptima Health Employees shall promptly disclose all potential, suspected, or actual conflicts of interest to CalOptima Health's Human Resources Department (HR) and shall personally withdraw

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from discussion, voting, or other decision-making process where an employee knows or has reason to know the employee has a real or apparent conflict of interest.

H. Designated CalOptima Health Employees in those positions listed in the CalOptima Health Conflict of Interest Code shall complete Statements of Economic Interests (FPPC Form 700) and a CalOptima Health Supplement to Form 700 upon hire, annually, and upon termination of employment. If an employee or an employee's immediate family member, as defined in the Political Reform Act, has a financial or employment relationship with a current or potential provider, supplier, vendor, consultant or member, the employee must disclose this fact in writing to HR.

1. CalOptima Health Employees are prohibited from performing a second job that would create a conflict of interest. Employees are required to promptly report any non-CalOptima Health job positions that might be considered one of the situations described in Section II.H.2., on an Employee Report of Outside Interest and/or Other Employment form provided by HR for approval. Employees are to resubmit the Employee Report of Outside Interest and/or Other Employment annually for subsequent approval. Employees are to notify HR when the approved activity ends.

2. CalOptima Health employees shall not participate in any of the following activities without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Health Board of Directors):

   a. Perform work or render services for any Contractor/Vendor/Provider, association of Contractors/Vendors/Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health;

   b. Perform work or hold a position with a job-related non-profit/charitable businesses or organization;

   c. Be a director, officer, or consultant of any Contractor/Vendor/Provider or association of Contractors/Vendors/Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health; or

   d. Permit his or her name to be used in any fashion that would tend to indicate a business connection with any Contractor/Vendor/Provider or association of Contractors/Vendors/Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health.

3. CalOptima Health Employees are prohibited from performing a second job during the same hours or schedule as their position with CalOptima Health.

I. Employees may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima Health in these activities.

J. As required in CalOptima Health's contract with the Department of Health Care Services (DHCS) and applicable state and federal laws and regulations, CalOptima Health shall avoid conflicts of interest in the employment of current and former state officers and employees.

K. CalOptima Health and each of its subcontractors and downstream subcontractors, must notify their DHCS Contract Manager within ten (10) working days of when they become aware of any

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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 CalOptima Health's contract with DHCS for Medi-Cal services.

~~J.~~L. Employees in Executive Staff positions shall not, for a period of twelve (12) months after leaving that position or employment with CalOptima Health, act as an agent for, or otherwise represent, for compensation, any other person, contractor, or organization, directly or indirectly, by negotiating, servicing, or soliciting contracts with CalOptima Health.

~~K.~~M. To avoid conflicts of interests or potential conflicts of interests, employees performing audit functions are precluded from auditing Health Networks (HNs) and or other contracted entities with which they were previously employed. This preclusion can be waived with the approval of the Executive Director of Network Operations in consultation with the Chief Compliance Officer and the Health Network and or other contracted entity.

~~L.~~N. Failure to adhere to this Policy, including failure to promptly disclose any potential or actual conflicts or seek an exception may result in corrective action, up to and including termination of employment and/or legal action. Conflicts that violate state or federal laws may result in regulatory or legal action, including possible fines and criminal prosecution.

III. PROCEDURE

A. HR shall:

1. Provide all new CalOptima Health Employees with a copy of this Policy and CalOptima Health's Code of Conduct.

2. Provide each designated CalOptima Health employee with a copy of the Conflict of Interest Code and a link to the County of Orange's eDisclosure System to the Form 700 Statement of Economic Interests, to complete when assuming office, annually, and upon termination of employment. HR will also provide the Supplement to Form 700 upon hire and annually.

3. Make the Employee Report of Outside Interest and/or Other Employment form available to all CalOptima Health employees.

4. Collect and review the completed Supplement to Form 700 forms and/or Employee Report of Outside Interest and/or Other Employment Forms and obtain necessary approvals where required. Notify CalOptima Health's Regulatory Affairs and Compliance (RAC) Department of any potential, suspected, or actual conflict of interest.

   a. Provide CalOptima Health's RAC Department with a description of the relationship and a conflict avoidance plan to avoid, neutralize, and/or mitigate the potential, suspected, and/or actual conflict of interest.

~~4.~~5. Not employ an individual holding a permanent or intermittent position in the State civil service or other appointed State official or an individual who was employed within the previous one (1) year as an appointee or civil service employee with DHCS, subject to certain exceptions which employment determination shall be made in conjunction with the Compliance Department.

B. All CalOptima Health Employees shall:

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1. Review and comply with this Policy, CalOptima Health's Code of Conduct, and the CalOptima Health Employee Handbook;

2. Avoid any actual or potential conflict between their personal interests and the interest of CalOptima Health;

3. Promptly report any job-related outside or personal positions or interests on the Employee Report of Outside Interest and/or Other Employment form and submit such forms to HR.

4. Not make, or participate in making, or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know he or she has a financial interest.

5. Not offer, pay, solicit or receive an incentive or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to induce the referral of business reimbursable under the Medi-Cal or Medicare programs or to induce an enrollee to use a particular practitioner, provider or supplier.

6. Promptly report any suspected or apparent violation of this Policy to CalOptima Health's HR Department with detailed information sufficient for HR to investigate the issue and cooperate with any subsequent investigation.

7. ~~CalOptima Health Employees~~If unsure as to whether a certain transaction, activity, or relationship constitutes a conflict of interest, ~~should~~ discuss it with their supervisor or HR for clarification.

8. Upon being notified that an actual or apparent conflict exists, and an exception is not granted, ~~the employee~~ must promptly resolve the conflict by:

   a. Terminating the outside activity;

   b. Cooperating in reassignment, when appropriate or reasonable;

   ~~b.~~c. Following the conflict of interest avoidance plan ~~or~~;

   ~~c.~~d. Resigning from CalOptima Health.

C. Designated CalOptima Health Employees in those positions listed in the CalOptima Health Conflict of Interest Code shall:

1. Upon assuming office, annually, and upon termination of employment, complete and submit a Statement of Economic Interests (FPPC Form 700) on the County of Orange eDisclosure system (https://cob.ocgov.com/disclosure); and

2. Complete a Supplement to Form 700 upon hire and annually.

IV. ATTACHMENT(S)

A. Conflict of Interest Code Exhibits A and B
B. Supplement to Form 700
C. Employee Report of Outside Interest and/or Other Employment Form

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V. REFERENCE(S)

A. California Government Code, §§1090 *et. seq.*
B. California Government Code, §1126
C. California Government Code, §§87206.3 and 87206.3(c)
D. CalOptima Health Code of Conduct
E. CalOptima Health Conflict of Interest Code
F. CalOptima Health Contract with the Department of Health Care Services (DHCS)
G. CalOptima Health Employee Handbook
H. CalOptima Health Policy AA.1204: Gifts, Honoraria and Travel Payments
I. CalOptima Health Policy AA.1216: Solicitation and Receipt of Gifts to CalOptima Health
J. Political Reform Act, Government Code §§81000-91014
K. Title 2, California Code of Regulations (C.C.R.), §§18730 *et seq.*
L. Title 22, California Code of Regulations, §53600
M. Title 42, United States Code, §§1320a-7b(b)
N. Title 42, Code of Federal Regulations, §460.68

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/08/2009	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
09/01/2022	Regular Meeting of the CalOptima Health Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
12/07/2023	Regular Meeting of the CalOptima Health Board of Directors
05/02/2024	Regular Meeting of the CalOptima Health Board of Directors
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2000	GA.8012	Conflicts of Interest	Administrative
Revised	07/01/2007	GA.8012	Conflicts of Interest	Administrative
Revised	05/04/2017	GA.8012	Conflicts of Interest	Administrative
Revised	02/07/2019	GA.8012	Conflicts of Interest	Administrative
Revised	12/03/2020	GA.8012	Conflicts of Interest	Administrative
Revised	09/01/2022	GA.8012	Conflicts of Interest	Administrative
Revised	12/01/2022	GA.8012	Conflicts of Interest	Administrative
Revised	05/04/2023	GA.8012	Conflicts of Interest	Administrative
Revised	12/07/2023	GA.8012	Conflicts of Interest	Administrative
Revised	05/02/2024	GA.8012	Conflicts of Interest	Administrative

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Action	Date	Policy	Policy Title	Program(s)
Revised	06/05/2025	GA.8012	Conflicts of Interest	Administrative

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IX. GLOSSARY

Term	Definition
CalOptima Health Employee(s)	For purposes of this policy, include, but are not limited to, all full-time and part-time regular CalOptima Health employees, all temporary employees, interns, CalOptima Health Board members, and applicable contractors and consultants.

For 20250605 BOD Review Only

Policy:	GA.8012
Title:	**Conflicts of Interest**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	02/01/2000
Revised Date:	06/05/2025
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250605 BOD Review Only

I. PURPOSE

This policy establishes guidelines and standards for CalOptima Health Employees to avoid conflicts of interest and incompatible outside activities.

II. POLICY

A. CalOptima Health Employees shall avoid anything that constitutes a real or apparent conflict between their personal interests and the interests of CalOptima Health.

B. CalOptima Health Employees shall avoid conflicts of interest and shall adhere to applicable state and federal laws and regulations, including, but not limited to:

1. California Government Code Section 81000 et seq., requiring all designated employees to comply with the reporting requirements in CalOptima Health's Conflict of Interest Code;

2. California Government Code Section 87100, prohibiting each CalOptima Health Employee from making, participating in making or in any way attempting to use his or her official position to influence a governmental decision in which he or she knows or has reason to know that he or she has a financial interest;

3. California Government Code section 1090, prohibiting each CalOptima Health Employee from being financially interested in any contract made by the employee in his or her official capacity, and prohibiting each employee from being a purchaser at any sale or vendor at any purchase made by him or her in his or her official capacity.

4. California Government Code section 1126, which prohibits each CalOptima Health Employee from engaging in any employment, activity, or enterprise for compensation which is inconsistent, incompatible, in conflict with, or inimical to his or her duties as a local agency officer or employee or with the duties, functions, or responsibilities of CalOptima Health.

5. Title 42 of the United States Code section 1320-7b(b), prohibiting the knowing and willful offer, payment, solicitation or receipt of incentives or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to induce the

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referral of business reimbursable under the Medi-Cal or Medicare programs or to induce an enrollee to use a particular practitioner, provider or supplier.

6. Title 42 of the Code of Federal Regulations section 460.68 regarding the disclosure and recusal requirement of the governing board for direct or indirect interest in any contract that supplies any administrative or care-related service or materials to PACE.

C. A conflict of interest exists in any situation in which an employee uses his or her position or association with CalOptima Health for personal or financial gain. The following guidelines are used to determine whether a real or apparent conflict of interest would exist.

1. *Avoidance of Unfair Competitive Advantage*. An employee's outside employment, consulting, or other business activity outside CalOptima Health may not influence decisions made by CalOptima Health in such a way as to give unfair competitive advantage to the employee's outside business activity.

2. *Use of Privileged or Official Information*. The use of privileged or official information for personal financial gain while employed with or after separating from employment is a type of conflict of interest and is prohibited. Privileged or official information is information that is known to an employee because of his or her employment with CalOptima Health but is not available to the public. The information covered under this provision includes, but is not limited to, personal health information (PHI), provider rates, personnel records, or proprietary information.

3. *Protection of Information Not Yet in Public Domain*. A CalOptima Health Employee acting as an independent consultant or as an employee of another organization may not use information, skills or knowledge obtained as a result of CalOptima Health employment, that is material or necessary to a current, in-progress, or proposed CalOptima Health project, that is proprietary to CalOptima Health and that is not yet in the public domain.

4. *Noncompetition with CalOptima Health*. An employee's outside employment or consulting activity must not compete with current or proposed CalOptima Health projects, programs or initiatives.

D. CalOptima Health Employees shall not handle member or provider issues, applications, requests, or cases on behalf of CalOptima Health for member(s) of the employee's own family or for personal friends.

E. CalOptima Health Employees shall comply with the Code of Conduct and CalOptima Health Policies AA.1204: Gifts, Honoraria, and Travel Payments and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health. Other than as permitted in CalOptima Health Policies, employees shall not receive gratuity, rebates, kickbacks, accommodation, or other unlawful consideration from any one provider, supplier, vendor, firm, or organization with whom CalOptima Health is currently doing or could potentially do business with. It is the responsibility of the employee to return any gift delivered to them and to notify the Clerk of the Board of such action.

F. CalOptima Health Employees shall be aware of what outside activities, investments, and/or positions may conflict with or detract from their effectiveness in employment with CalOptima Health and shall avoid such conflicts.

G. CalOptima Health Employees shall promptly disclose all potential, suspected, or actual conflicts of interest to CalOptima Health's Human Resources Department (HR) and shall personally withdraw

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from discussion, voting, or other decision-making process where an employee knows or has reason to know the employee has a real or apparent conflict of interest.

H. Designated CalOptima Health Employees in those positions listed in the CalOptima Health Conflict of Interest Code shall complete Statements of Economic Interests (FPPC Form 700) and a CalOptima Health Supplement to Form 700 upon hire, annually, and upon termination of employment. If an employee or an employee's immediate family member, as defined in the Political Reform Act, has a financial or employment relationship with a current or potential provider, supplier, vendor, consultant or member, the employee must disclose this fact in writing to HR.

1. CalOptima Health Employees are prohibited from performing a second job that would create a conflict of interest. Employees are required to promptly report any non-CalOptima Health job positions that might be considered one of the situations described in Section II.H.2., on an Employee Report of Outside Interest and/or Other Employment form provided by HR for approval. Employees are to resubmit the Employee Report of Outside Interest and/or Other Employment annually for subsequent approval. Employees are to notify HR when the approved activity ends.

2. CalOptima Health employees shall not participate in any of the following activities without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Health Board of Directors):

   a. Perform work or render services for any Contractor/Vendor/Provider, association of Contractors/Vendors/Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health;

   b. Perform work or hold a position with a job-related non-profit/charitable businesses or organization;

   c. Be a director, officer, or consultant of any Contractor/Vendor/Provider or association of Contractors/Vendors/Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health; or

   d. Permit his or her name to be used in any fashion that would tend to indicate a business connection with any Contractor/Vendor/Provider or association of Contractors/Vendors/Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health.

3. CalOptima Health Employees are prohibited from performing a second job during the same hours or schedule as their position with CalOptima Health.

I. Employees may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima Health in these activities.

J. As required in CalOptima Health's contract with the Department of Health Care Services (DHCS) and applicable state and federal laws and regulations, CalOptima Health shall avoid conflicts of interest in the employment of current and former state officers and employees.

K. CalOptima Health and each of its subcontractors and downstream subcontractors, must notify their DHCS Contract Manager within ten (10) working days of when they become aware of any

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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 CalOptima Health's contract with DHCS for Medi-Cal services.

L. Employees in Executive Staff positions shall not, for a period of twelve (12) months after leaving that position or employment with CalOptima Health, act as an agent for, or otherwise represent, for compensation, any other person, contractor, or organization, directly or indirectly, by negotiating, servicing, or soliciting contracts with CalOptima Health.

M. To avoid conflicts of interests or potential conflicts of interests, employees performing audit functions are precluded from auditing Health Networks (HNs) and or other contracted entities with which they were previously employed. This preclusion can be waived with the approval of the Executive Director of Network Operations in consultation with the Chief Compliance Officer and the Health Network and or other contracted entity.

N. Failure to adhere to this Policy, including failure to promptly disclose any potential or actual conflicts or seek an exception may result in corrective action, up to and including termination of employment and/or legal action. Conflicts that violate state or federal laws may result in regulatory or legal action, including possible fines and criminal prosecution.

III. PROCEDURE

A. HR shall:

1. Provide all new CalOptima Health Employees with a copy of this Policy and CalOptima Health's Code of Conduct.

2. Provide each designated CalOptima Health employee with a copy of the Conflict of Interest Code and a link to the County of Orange's eDisclosure System to the Form 700 Statement of Economic Interests, to complete when assuming office, annually, and upon termination of employment. HR will also provide the Supplement to Form 700 upon hire and annually.

3. Make the Employee Report of Outside Interest and/or Other Employment form available to all CalOptima Health employees.

4. Collect and review the completed Supplement to Form 700 forms and/or Employee Report of Outside Interest and/or Other Employment Forms and obtain necessary approvals where required. Notify CalOptima Health's Regulatory Affairs and Compliance (RAC) Department of any potential, suspected, or actual conflict of interest.

   a. Provide CalOptima Health's RAC Department with a description of the relationship and a conflict avoidance plan to avoid, neutralize, and/or mitigate the potential, suspected, and/or actual conflict of interest.

5. Not employ an individual holding a permanent or intermittent position in the State civil service or other appointed State official or an individual who was employed within the previous one (1) year as an appointee or civil service employee with DHCS, subject to certain exceptions which employment determination shall be made in conjunction with the Compliance Department.

B. All CalOptima Health Employees shall:

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1. Review and comply with this Policy, CalOptima Health's Code of Conduct, and the CalOptima Health Employee Handbook;

2. Avoid any actual or potential conflict between their personal interests and the interest of CalOptima Health;

3. Promptly report any job-related outside or personal positions or interests on the Employee Report of Outside Interest and/or Other Employment form and submit such forms to HR.

4. Not make, or participate in making, or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know he or she has a financial interest.

5. Not offer, pay, solicit or receive an incentive or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to induce the referral of business reimbursable under the Medi-Cal or Medicare programs or to induce an enrollee to use a particular practitioner, provider or supplier.

6. Promptly report any suspected or apparent violation of this Policy to CalOptima Health's HR Department with detailed information sufficient for HR to investigate the issue and cooperate with any subsequent investigation.

7. If unsure as to whether a certain transaction, activity, or relationship constitutes a conflict of interest, discuss it with their supervisor or HR for clarification.

8. Upon being notified that an actual or apparent conflict exists, and an exception is not granted, must promptly resolve the conflict by:

    a. Terminating the outside activity;

    b. Cooperating in reassignment, when appropriate or reasonable;

    c. Following the conflict of interest avoidance plan or;

    d. Resigning from CalOptima Health.

C. Designated CalOptima Health Employees in those positions listed in the CalOptima Health Conflict of Interest Code shall:

1. Upon assuming office, annually, and upon termination of employment, complete and submit a Statement of Economic Interests (FPPC Form 700) on the County of Orange eDisclosure system (https://cob.ocgov.com/disclosure); and

2. Complete a Supplement to Form 700 upon hire and annually.

IV. ATTACHMENT(S)

A. Conflict of Interest Code Exhibits A and B
B. Supplement to Form 700
C. Employee Report of Outside Interest and/or Other Employment Form

V. REFERENCE(S)

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A. California Government Code, §§1090 *et. seq.*
B. California Government Code, §1126
C. California Government Code, §§87206.3 and 87206.3(c)
D. CalOptima Health Code of Conduct
E. CalOptima Health Conflict of Interest Code
F. CalOptima Health Contract with the Department of Health Care Services (DHCS)
G. CalOptima Health Employee Handbook
H. CalOptima Health Policy AA.1204: Gifts, Honoraria and Travel Payments
I. CalOptima Health Policy AA.1216: Solicitation and Receipt of Gifts to CalOptima Health
J. Political Reform Act, Government Code §§81000-91014
K. Title 2, California Code of Regulations (C.C.R.), §§18730 *et seq.*
L. Title 22, California Code of Regulations, §53600
M. Title 42, United States Code, §§1320a-7b(b)
N. Title 42, Code of Federal Regulations, §460.68

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/08/2009	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
09/01/2022	Regular Meeting of the CalOptima Health Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
12/07/2023	Regular Meeting of the CalOptima Health Board of Directors
05/02/2024	Regular Meeting of the CalOptima Health Board of Directors
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2000	GA.8012	Conflicts of Interest	Administrative
Revised	07/01/2007	GA.8012	Conflicts of Interest	Administrative
Revised	05/04/2017	GA.8012	Conflicts of Interest	Administrative
Revised	02/07/2019	GA.8012	Conflicts of Interest	Administrative
Revised	12/03/2020	GA.8012	Conflicts of Interest	Administrative
Revised	09/01/2022	GA.8012	Conflicts of Interest	Administrative
Revised	12/01/2022	GA.8012	Conflicts of Interest	Administrative
Revised	05/04/2023	GA.8012	Conflicts of Interest	Administrative
Revised	12/07/2023	GA.8012	Conflicts of Interest	Administrative
Revised	05/02/2024	GA.8012	Conflicts of Interest	Administrative
Revised	06/05/2025	GA.8012	Conflicts of Interest	Administrative

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IX. GLOSSARY

Term	Definition
CalOptima Health Employee(s)	For purposes of this policy, include, but are not limited to, all full-time and part-time regular CalOptima Health employees, all temporary employees, interns, CalOptima Health Board members, and applicable contractors and consultants.

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Conflict of Interest Code
EXHIBIT A

Approved May 2, 2024, by
CalOptima Health Board of Directors

Entity: Other Misc. Authorities, Districts and Commissions
Agency: CalOptima Health

Position	Disclosure Category	Files With
Associate Director I	OC-41	COB
Associate Director II	OC-41	COB
Buyer	OC-01	COB
Buyer, Int.	OC-01	COB
Buyer, Sr.	OC-01	COB
Chief Administrative Officer	OC-01	COB
Chief Compliance Officer	OC-01	COB
Chief Executive Officer	OC-01	COB
Chief Financial Officer	OC-01	COB
Chief Health Equity Officer	OC-01	COB
Chief Human Resources Officer	OC-01	COB
Chief Information Officer	OC-01	COB
Chief Medical Officer	OC-01	COB
Chief of Staff	OC-01	COB
Chief Operating Officer	OC-01	COB
Clerk of the Board	OC-06	COB
Clinical Pharmacist	OC-20	COB
Consultant	OC-01	Agency
Contract Administrator	OC-06	COB
Contracts Manager	OC-06	COB
Contracts Manager, Sr.	OC-06	COB
Contracts Specialist	OC-06	COB
Contracts Specialist, Int.	OC-06	COB
Contracts Specialist, Sr.	OC-06	COB
Controller	OC-01	COB
Deputy Chief Medical Officer	OC-01	COB
Director I	OC-01	COB
Director II	OC-01	COB

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Approved May 2, 2024, by
CalOptima Health Board of Directors

Position	Disclosure Category	Files With
Director III	OC-01	COB
Director IV	OC-01	COB
Enterprise Analytics Manager	OC-06	COB
Executive Director	OC-01	COB
Financial Analyst I	OC-01	COB
Financial Analyst II	OC-01	COB
Financial Analyst III	OC-01	COB
Financial Analyst IV	OC-01	COB
Financial Reporting Analyst	OC-01	COB
Litigation Support Specialist	OC-41	COB
Manager, Accounting	OC-01	COB
Manager, Actuary	OC-01	COB
Manager, Audit and Oversight	OC-01	COB
Manager, Behavioral Health	OC-41	COB
Manager, Business Integration	OC-06	COB
Manager, Case Management	OC-41	COB
Manager, Claims	OC-41	COB
Manager, Clinic Operations	OC-06	COB
Manager, Clinical Pharmacists	OC-20	COB
Manager, Coding Quality	OC-06	COB
Manager, Communications	OC-13	COB
Manager, Community Relations	OC-06	COB
Manager, Contracting	OC-41	COB
Manager, Cultural & Linguistics	OC-06	COB
Manager, Customer Service	OC-41	COB
Manager, Electronic Business	OC-06	COB
Manager, Encounters	OC-06	COB
Manager, Environmental Health & Safety	OC-06	COB
Manager, Finance	OC-01	COB
Manager, Financial Analysis	OC-01	COB

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Conflict of Interest Code
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Approved May 2, 2024, by
CalOptima Health Board of Directors

Position	Disclosure Category	Files With
Manager, Government Affairs	OC-41	COB
Manager, Grievance and Appeals	OC-41	COB
Manager, Human Resources	OC-11	COB
Manager, Information Technology Services	OC-08	COB
Manager, Long Term Support Services	OC-41	COB
Manager, Marketing and Enrollment (PACE)	OC-06	COB
Manager, Member Liaison Program	OC-41	COB
Manager, Member Outreach & Education	OC-41	COB
Manager, MSSP	OC-41	COB
Manager, OneCare Clinical	OC-41	COB
Manager, OneCare Customer Service	OC-41	COB
Manager, Outreach & Enrollment	OC-41	COB
Manager, PACE Center	OC-41	COB
Manager, Population Health Management	OC-41	COB
Manager, Process Excellence	OC-41	COB
Manager, Program Implementation	OC-06	COB
Manager, Provider Data Management Services	OC-41	COB
Manager, Provider Network	OC-41	COB
Manager, Provider Relations	OC-41	COB
Manager, Purchasing	OC-01	COB
Manager, QI Initiatives	OC-41	COB
Manager, Quality Analytics	OC-06	COB
Manager, Quality Improvement	OC-41	COB
Manager, Regulatory Affairs and Compliance	OC-41	COB
Manager, Reporting & Financial Compliance	OC-01	COB
Manager, Strategic Development	OC-41	COB
Manager, Utilization Management	OC-06	COB
Medical Case Manager	OC-41	COB
Medical Case Manager (LVN)	OC-41	COB
Medical Director	OC-01	COB

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Conflict of Interest Code
EXHIBIT A

Approved May 2, 2024, by
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Position	Disclosure Category	Files With
Medical Services Case Manager	OC-41	COB
Nurse Practitioner (PACE)	OC-41	COB
OneCare Operations Manager	OC-41	COB
Pharmacy Resident	OC-20	COB
Pharmacy Services Specialist	OC-20	COB
Pharmacy Services Specialist, Int.	OC-20	COB
Pharmacy Services Specialist, Sr.	OC-20	COB
Policy Advisor, Sr.	OC-41	COB
Principal Financial Analyst	OC-01	COB
Privacy Manager	OC-41	COB
Privacy Officer	OC-41	COB
Process Excellence Manager II	OC-41	COB
Process Excellence Manager III	OC-41	COB
Process Excellence Manager IV	OC-41	COB
Program Manager	OC-06	COB
Program Manager, Sr.	OC-06	COB
Project Manager II	OC-O6	COB
Project Manager III	OC-O6	COB
Project Manager IV	OC-O6	COB
QI Nurse Specialist (RN or LVN)	OC-06	COB
Records Manager	OC-06	COB
Regulatory Affairs and Compliance Analyst	OC-41	COB
Regulatory Affairs and Compliance Analyst, Sr.	OC-41	COB
Regulatory Affairs and Compliance, Lead	OC-41	COB
RN (PACE)	OC-41	COB
Sr Director	OC-01	COB
Sr Manager I	OC-01	COB
Sr Manager II	OC-01	COB
Sr Manager III	OC-01	COB
Sr Manager IV	OC-01	COB

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Conflict of Interest Code
EXHIBIT A

Approved May 2, 2024, by
CalOptima Health Board of Directors

Position	Disclosure Category	Files With
Supervisor, Accounting	OC-01	COB
Supervisor, Audit and Oversight	OC-01	COB
Supervisor, Behavioral Health	OC-41	COB
Supervisor, Budgeting	OC-01	COB
Supervisor, Case Management	OC-41	COB
Supervisor, Claims	OC-06	COB
Supervisor, Coding Initiatives	OC-06	COB
Supervisor, Credentialing	OC-41	COB
Supervisor, Customer Service	OC-06	COB
Supervisor, Data Entry	OC-06	COB
Supervisor, Day Center (PACE)	OC-06	COB
Supervisor, Dietary Services (PACE)	OC-41	COB
Supervisor, Encounters	OC-06	COB
Supervisor, Facilities	OC-41	COB
Supervisor, Finance	OC-01	COB
Supervisor, Grievance and Appeals	OC-41	COB
Supervisor, Information Technology Services	OC-08	COB
Supervisor, Long Term Support Services	OC-41	COB
Supervisor, Medical Assistant	OC-41	COB
Supervisor, Member Outreach and Education	OC-06	COB
Supervisor, MSSP	OC-06	COB
Supervisor, Nursing Services (PACE)	OC-41	COB
Supervisor, OneCare Customer Service	OC-06	COB
Supervisor, Payroll	OC-06	COB
Supervisor, Pharmacist	OC-20	COB
Supervisor, Population Health Management	OC-41	COB
Supervisor, Provider Data Management Services	OC-06	COB
Supervisor, Provider Relations	OC-41	COB
Supervisor, Quality Analytics	OC-06	COB
Supervisor, Quality Improvement	OC-41	COB

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Conflict of Interest Code
EXHIBIT A

Approved May 2, 2024, by
CalOptima Health Board of Directors

Position	Disclosure Category	Files With
Supervisor, Regulatory Affairs and Compliance	OC-41	COB
Supervisor, Social Work (PACE)	OC-41	COB
Supervisor, Therapy Services (PACE)	OC-41	COB
Supervisor, Utilization Management	OC-06	COB

Total: 154

OFFICIALS WHO ARE SPECIFIED IN GOVERNMENT CODE SECTION 87200

Officials who are specified in Government Code section 87200 (including officials who manage public investments, as defined by 2 Cal. Code of Regs. § 18700.3 (b)), are NOT subject to the Agency's Conflict of Interest Code but are subject to the disclosure requirements of the Political Reform Act, Government Code section 87100, et seq. Gov't Code § 87203. These positions are listed here for informational purposes only.

The positions listed below are officials who are specified in Government Code section 87200:

Alternate Member of the Board of Directors	Files with	COB
Chief Executive Officer	Files with	COB
Chief Financial Officer	Files with	COB
Member of the Board of Directors	Files with	COB

The disclosure requirements for these positions are set forth in Government Code section 87200, et. seq. They require the disclosure of interests in real property in the agency's jurisdiction, as well as investments, business positions and sources of income (including gifts, loans and travel payments).

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Disclosure Descriptions
EXHIBIT B

Entity: **Other Misc. Authorities, Districts and Commissions Agency:** **CalOptima Health**

Disclosure Category	Disclosure Description
87200 Filer	Form 87200 filers shall complete all schedules for Form 700 and disclose all reportable sources of income, interests in real property, investments and business positions in business entities, if applicable, pursuant to Government Code Section 87200 *et seq*...
OC-01	All interests in real property in Orange County, the authority or the District as applicable, as well as investments, business positions and sources of income (including gifts, loans and travel payments).
OC-06	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide leased facilities and goods, supplies, equipment, vehicles, machinery or services (including training and consulting services) of the types used by the County Department, Authority or District, as applicable.
OC-08	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that develop or provide computer hardware/software, voice data communications, or data processing goods, supplies, equipment, or services (including training and consulting services) used by the County Department, Authority or District, as applicable.
OC-11	All interests in real property in Orange County or located entirely or partly within the Authority or District boundaries as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that are engaged in the supply of equipment related to recruitment, employment search & marketing, classification, training, or negotiation with personnel; employee benefits, and health and welfare benefits.
OC-13	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that produce or provide promotional items for public outreach programs; present, facilitate, market or otherwise act as agent for media relations with regard to public relations; provide printing, copying, or mail services; or provide training for or development of customer service representatives.
OC-20	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide pharmaceutical services, supplies, materials or equipment.

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Disclosure Category	Disclosure Description
OC-30	Consultants shall be included in the list of designated employees and shall disclose pursuant to the broadest category in the code subject to the following limitation: The County Department Head/Director/General Manager/Superintendent/etc. may determine that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant's duties and based upon that description, a statement of the extent of disclosure required. The determination of disclosure is a public record and shall be filed with the Form 700 and retained by the Filing Officer for public inspection.
OC-41	All interests in real property in Orange County, the District or Authority, as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide services, supplies, materials, machinery, vehicles, or equipment (including training and consulting services) used by the County Department, Authority or District, as applicable.

Grand Total: 9

SUPPLEMENT TO FORM

700 CALOPTIMA HEALTH

Please print:

Name: _____

The purpose of this disclosure form is to ensure that decisions are in the best interest of CalOptima Health and that no individual achieves personal gain because of his / her position with or without knowledge of CalOptima Health.

Please complete the following:

1. Are you or anyone in your family a director, officer, employee or owner in any business or entity (e.g., bank, real estate brokerage firm, consulting firm, construction company, insurance broker, architectural, law firm, medical group, etc.) which has done business in the past 12 months with CalOptima Health, or currently is or contemplates doing business with CalOptima Health in the next 12 months? _____(yes or no)

   Entity for these purposes includes any for profit, non-profit or public entity. *If yes, please disclose at end*

Please explain your relationship with such business or entity and the transaction with CalOptima Health.

_____

_____

_____

2. Are there any circumstances or other matters of a personal or family nature, direct or indirect, which could conflict with the interests of CalOptima Health ____(yes or no) *If yes, please disclose at end.*

3. Disclose any other activities which you or anyone in your family are engaging in, or are considering engaging in, which may be deemed by CalOptima Health's management or Board to present a potential conflict of interest.

_____ _____

Signature Date

Please disclose any information here:

_____

_____

_____

_____

_____

(Please attach additional sheets if needed)

Human Resources *Approved:*

Employee Report of Outside Interest and/or Other Employment

Employees are required to submit this form to Human Resources for determination of any outside interest(s) they may have which could be perceived as a potential conflict of interest with their employment with CalOptima Health. It is understood that not all personal outside interest(s) which may interact with and/or relate to CalOptima Health employment constitute a conflict of interest. By reporting any such related outside interest(s), it is hoped that any potential conflict may be avoided.

Name_____ **Position** _____

Department_____ **Supervisor** _____

A) Other Job / Position:

~~Place of Employment~~Name of Employer or Activity _____

Location/Address _____

Hours/Schedule _____

B) **Outside Interest:** Describe the nature of your association/position in which you have an outside interest, which may have a real or perceived connection, influence or interaction with your employment/position at CalOptima Health:

Explain any actions/precautions that you will take to avoid any conflict of interest with your CalOptima Health employment:

I understand that it is my responsibility to ensure there are no conflicts of interest with my CalOptima Health employment. If approved, I will notify Human Resources when the outside activity ends and for ongoing activities will resubmit this form annually for reapproval:

Employee Name (please print):_____

Employee signature: _____ Date _____

Approved by:

Manager/Executive: _____ Date _____

Human Resources: Date

Compliance (if necessary): _____ Date _____

~~**Human Resources:** Date~~

Legal (if necessary): _____ Date _____

Additional Comments:

This form must be typed. Signatures need to be in blue or black ink.

Employee Report of Outside Interest and/or Other Employment

Employees are required to submit this form to Human Resources for determination of any outside interest(s) they may have which could be perceived as a potential conflict of interest with their employment with CalOptima Health. It is understood that not all personal outside interest(s) which may interact with and/or relate to CalOptima Health employment constitute a conflict of interest. By reporting any such related outside interest(s), it is hoped that any potential conflict may be avoided.

Name_____ **Position** _____

Department_____ **Supervisor** _____

A) **Other Job / Position:**

Name of Employer or Activity _____

Location/Address _____

Hours/Schedule _____

B) **Outside Interest:** Describe the nature of your association/position in which you have an outside interest, which may have a real or perceived connection, influence or interaction with your employment/position at CalOptima Health:

Explain any actions/precautions that you will take to avoid any conflict of interest with your CalOptima Health employment:

I understand that it is my responsibility to ensure there are no conflicts of interest with my CalOptima Health employment. If approved, I will notify Human Resources when the outside activity ends and for ongoing activities will resubmit this form annually for reapproval:

Employee Name (please print):_____

Employee signature: _____ Date _____

Approved by:

Manager/Executive: _____ Date _____

Human Resources: _____ Date _____

Compliance (if necessary): _____ Date _____

Legal (if necessary): _____ Date _____

Additional Comments:

This form must be typed. Signatures need to be in blue or black ink.

Policy:	GA.8020
Title:	**9/80 Work Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ~~☐ OneCare Connect~~ ☐ PACE ~~☒ Administrative~~

For 20250605 BOD Review Only

I. PURPOSE

This policy outlines how CalOptima Health will administer an alternate workweek schedule commonly referred to as a 9/80 Work Schedule.

II. POLICY

A. Based on operational needs, department managers may establish a 9/80 Work ~~Schedules~~Schedule within their departments. ~~A~~The 9/80 Work Schedule is eighty (80) hours of work in a two (2) week period worked over nine (9) days, instead of the traditional ten (10) days. ~~–~~This alternate work schedule ~~may~~should provide the department with improved coverage and scheduling~~ and employees with another way to manage work and non-work responsibilities.~~ .

B. Customer Service Remains a Priority: The 9/80 Work Schedule is not an entitlement and will not be provided at the expense of service to the public and must not adversely affect workloads or the ~~organization's~~organizational or a ~~department's~~departmental ability to provide coverage and maintain service levels. Department managers, at their discretion, may discontinue an individual's, group's, or department's participation in the 9/80 Work Schedule based on business needs.

C. Eligibility: ~~After completing initial on-boarding and training requirements, full-time employees may be~~Management will determine eligible~~,~~ positions based on business needs and Member service expectations in accordance with ~~supervisory approval, to participate in the~~ 9/80 Work Schedule~~. An employee must obtain supervisory approval to participate in the 9/80 Work Schedule. A 9/80 schedule is not available for Executive Level Positions, unless approved by the Chief Executive Officer. Initial training requirements may vary by department, but typically do not exceed ninety (90) calendar days.~~ Guidelines. Individual 9/80 Work Schedules are set based on the pre-determined schedules ~~for payroll~~ and at the discretion of the department manager who will designate the hours for each day, ~~as well as the day off,~~ based on business needs~~, which~~. Schedules shall be consistent with the 9/80 Federal Labor Standards Act (FLSA) Workweek definition. Employees not meeting job standards, expectations, and/or on a Performance Improvement Plan may ~~not participate in the compressed work~~be returned to a standard 5/40 schedule until performance and/or behavior standards are met. ~~-~~Managers will review such exceptions with Human

Resources (HR) before ~~denying the option. Individuals who do not wish to participate may continue to work a standard forty (40) hour week, eight (8) hours a day.~~removing the 9/80 Work Schedule.

~~D. Approval: An employee must complete a 9/80 Workweek Request Form, acknowledge that they received and read this policy, and obtain supervisory approval before submitting the form to HR. Non-Exempt Employees cannot begin their 9/80 Work Schedule until they have received written approval from HR that outlines the approved 9/80 schedule start date.~~

~~E. Transitioning to the 9/80 Work Schedule: When an employee transitions from an eight (8) hour per day workweek to a 9/80 Work Schedule, there will be a necessary change in the beginning of the FLSA Workweek. This results in a situation in which some of the hours fall into both the old FLSA Workweek and the new FLSA Workweek. This could result in fewer or more than eighty (80) hours on an employee's paycheck for that transitional period. If the result is more than eighty (80) hours, a calculation of overtime will be made for an employee eligible for overtime, which includes those hours in both the old and new workweeks, and the greater of the two (2) amounts will be paid to the employee at time and a half. When possible, HR may require a Non-Exempt Employee to work a half partial day during the transition week to both minimize overtime worked and ensure that the employee receives a full paycheck.~~

~~F. Hours of Work: CalOptima daily start times will continue to be flexible with each employee committing to a starting time no earlier than 6:00 a.m. Lunch breaks are pre-approved for one-half (1/2) hour. The option to extend to one (1) hour is based on manager's approval.~~

~~G.~~D. Paid Time Off (PTO): PTO accrual will remain the same for participating employees. ~~-~~When an employee takes a day off pursuant to CalOptima Health Policy GA.8018: Paid Time Off, the accrual will be depleted by the number of scheduled hours for that day. For example, if an employee takes a PTO day on one (1) of their nine (9) hour days, nine (9) hours of PTO time will be removed from their total available PTO hours. ~~-~~Holiday pay shall remain at eight (8) hours.~~-~~ When a holiday falls on a regular nine (9) hour workday for a Non-Exempt Employee, the employee has the option of using one (1) hour of accrued PTO time, or if approved by their supervisor, the option of working one (1) hour of make-up time. Should a holiday fall on an employee's scheduled day off, the employee will be permitted to take off eight hours in-lieu of the holiday time off in the same workweek as the holiday.

~~H.~~E. Overtime: It is possible an employee's 9/80 Work Schedule may not generally correspond with ~~CalOptima's~~CalOptima Health's pay periods; therefore, adjustments to overtime compensation due cannot be calculated until the completion of the employee's workweek. ~~-~~This may result in one (1) pay period's delay in the employee receiving ~~the~~ overtime compensation.

~~I.~~F. Employee Conduct: Employees must obtain approval to adjust their work schedule and work hours. Failure to adhere to assigned work hours, tardiness, and excessive absenteeism may lead to revocation of the 9/80 Work Schedule for the individual. ~~-~~If necessary, as a condition of participating in the 9/80 Work Schedule, employees must agree to work on a scheduled day off for an urgent situation, or as ~~compelled~~required by business needs as determined by the employee's manager. ~~-~~Non-Exempt ~~employees~~Employees required to work on their scheduled day off may incur overtime if the total hours worked in the FLSA workweek exceed forty (40) hours. ~~Employees are encouraged to use days off to attend to personal business like medical/dental appointments for themselves and family members.~~

~~J.~~G. Termination of Program: The 9/80 Work Schedule is an optional program. ~~-~~CalOptima Health reserves the right to, at any time, discontinue the entire program and/or an individual employee's participation in the program, for any reason at management discretion. Should a manager choose to

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remove an employee from participating in the 9/80 Work Schedule, the manager must consult with HR in advance to develop a transition plan. Employees are not allowed to change their work schedules without prior approval from HR and their manager. Any changes in schedules by Non-Exempt Employees must be within the same FLSA workweek.

III. PROCEDURE

~~Responsible Party~~	~~Action~~
~~Employee~~	~~Complete the 9/80 Workweek Request Form and forward to supervisor for review and approval.~~ ~~▪ Non-Exempt Employees must submit the applicable request form to HR no less than two (2) weeks in advance of the requested 9/80 start date.~~ ~~▪ Exempt employees must submit the form at least one (1) week in advance of the requested 9/80 start date.~~
~~Supervisor~~	~~Review form and approve or deny.~~ ~~▪ Establish work schedule with the employee.~~ ~~▪ If approved, forward form to HR in advance of the requested 9/80 Work Schedule start date.~~
~~Human Resources~~	~~Review request and approve or deny.~~ ~~▪ If approved, determine employee's new workweek and send an email to the employee to outline when the new workweek will begin and what hours must be worked in the transition week to minimize overtime.~~

Not Applicable

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Employee Handbook
B. CalOptima Health Policy GA.8018: Paid Time Off
C. Title 29, Code of Federal Regulations (C.F.R.), §778.105
D. 9/80 Worksheet Request Forms (Exempt & Non-Exempt)
E. 9/80 Work Schedule Guidelines

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8020	9/80 Work Schedule	Administrative
Revised	02/01/2014	GA.8020	9/80 Work Schedule	Administrative
Revised	10/01/2014	GA.8020	9/80 Work Schedule	Administrative
Revised	12/01/2016	GA.8020	9/80 Work Schedule	Administrative
Revised	12/03/2020	GA.8020	9/80 Work Schedule	Administrative
Revised	06/02/2022	GA.8020	9/80 Work Schedule	Administrative
Revised		GA.8020	9/80 Work Schedule	Administrative

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IX. GLOSSARY

Term	Definition
9/80 Federal Labor Standards Act (FLSA) Workweek	Under the Fair Labor Standards Act, the workweek is defined as a fixed and regularly recurring period of seven (7) consecutive twenty-four (24) hour periods, or one hundred sixty-eight (168) hours (29 C.F.R. §778.105). The 9/80 workweek begins on the employee's eight (8) hour day, exactly four (4) hours after the scheduled start time and ends exactly three (3) hours and fifty-nine (59) minutes after the scheduled start time on the same day the following week. This is commonly referred to as a "day divide," in which four (4) hours of the eight (8) hour day occurs in one (1) week, and four (4) hours occurs in the following week. Department supervisors/managers and HR can answer questions about day divides.
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. in a pay period. The eight (8) hour workday must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 Work Schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9) hour days and one (1) eight (8) hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9) hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) Workweek.
~~9/80 Federal Labor Standards Act (FLSA) Workweek~~	~~Under the Fair Labor Standards Act, the workweek is defined as a fixed and regularly recurring period of seven (7) consecutive twenty-four (24) hour periods, or one hundred sixty-eight (168) hours (29 C.F.R. §778.105). The 9/80 workweek begins on the employee's eight (8) hour day, exactly four (4) hours after the scheduled start time and ends exactly three (3) hours and fifty-nine (59) minutes after the scheduled start time on the same day the following week. This is commonly referred to as a "day divide," in which four (4) hours of the eight (8) hour day occurs in one (1) week, and four (4) hours occurs in the following week. Department supervisors/managers and HR can answer questions about day divides.~~
~~Executive Level Position~~	~~The position of Executive Director or above.~~
Exempt Employee	Exempt status is determined by the Human Resources Department based on the position title and duties and responsibilities of the position and consistent with the federal Fair Labor Standards Act (FLSA) regulations. Although an employee's classification may meet applicable federal and/or state exemption criteria, the position may nevertheless be designated as non-exempt. For purposes of this policy, exempt employees do not earn overtime compensation.
Non-Exempt Employee	Non-Exempt status applies to all employees who are not identified by Human Resources as exempt. Non-Exempt employees are paid on an hourly basis and are eligible for overtime compensation. Although an employee's classification may qualify for applicable federal exemptions from the FLSA exemption criteria, the position may nevertheless be designated as non-exempt.
Performance Improvement Plan	A developmental coaching tool used to document performance and behavioral deficiencies or issues and create an action plan with goals and

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	due dates to help employees correct and/or improve performance and behavior while still holding them accountable for past performance.

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Policy:	GA.8020
Title:	**9/80 Work Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250605 BOD Review Only

I. PURPOSE

This policy outlines how CalOptima Health will administer an alternate workweek schedule commonly referred to as a 9/80 Work Schedule.

II. POLICY

A. Based on operational needs, department managers may establish a 9/80 Work Schedule within their departments. The 9/80 Work Schedule is eighty (80) hours of work in a two (2) week period worked over nine (9) days, instead of the traditional ten (10) days. This alternate work schedule should provide the department with improved coverage and scheduling.

B. Customer Service Remains a Priority: The 9/80 Work Schedule is not an entitlement and will not be provided at the expense of service to the public and must not adversely affect workloads or the organizational or a departmental ability to provide coverage and maintain service levels. Department managers, at their discretion, may discontinue an individual's, group's, or department's participation in the 9/80 Work Schedule based on business needs.

C. Eligibility: Management will determine eligible positions based on business needs and Member service expectations in accordance with 9/80 Work Schedule Guidelines. Individual 9/80 Work Schedules are set based on the pre-determined schedules and at the discretion of the department manager who will designate the hours for each day, based on business needs. Schedules shall be consistent with the 9/80 Federal Labor Standards Act (FLSA) Workweek definition. Employees not meeting job standards, expectations, and/or on a Performance Improvement Plan may be returned to a standard 5/40 schedule until performance and/or behavior standards are met. Managers will review such exceptions with Human Resources (HR) before removing the 9/80 Work Schedule.

D. Paid Time Off (PTO): PTO accrual will remain the same for participating employees. When an employee takes a day off pursuant to CalOptima Health Policy GA.8018: Paid Time Off, the accrual will be depleted by the number of scheduled hours for that day. For example, if an employee takes a PTO day on one (1) of their nine (9) hour days, nine (9) hours of PTO time will be removed from their total available PTO hours. Holiday pay shall remain at eight (8) hours. When a holiday falls on a regular nine (9) hour workday for a Non-Exempt Employee, the employee has the option of using one (1) hour of accrued PTO time, or if approved by their supervisor, the option of working one (1)

hour of make-up time. Should a holiday fall on an employee's scheduled day off, the employee will be permitted to take off eight hours in-lieu of the holiday time off in the same workweek as the holiday.

E. Overtime: It is possible an employee's 9/80 Work Schedule may not generally correspond with CalOptima Health's pay periods; therefore, adjustments to overtime compensation due cannot be calculated until the completion of the employee's workweek. This may result in one (1) pay period's delay in the employee receiving overtime compensation.

F. Employee Conduct: Employees must obtain approval to adjust their work schedule and work hours. Failure to adhere to assigned work hours, tardiness, and excessive absenteeism may lead to revocation of the 9/80 Work Schedule for the individual. If necessary, as a condition of participating in the 9/80 Work Schedule, employees must agree to work on a scheduled day off for an urgent situation, or as required by business needs as determined by the employee's manager. Non-Exempt Employees required to work on their scheduled day off may incur overtime if the total hours worked in the FLSA workweek exceed forty (40) hours.

G. Termination of Program: The 9/80 Work Schedule is an optional program. CalOptima Health reserves the right to, at any time, discontinue the entire program and/or an individual employee's participation in the program, for any reason at management discretion. Should a manager choose to remove an employee from participating in the 9/80 Work Schedule, the manager must consult with HR in advance to develop a transition plan. Employees are not allowed to change their work schedules without prior approval from HR and their manager. Any changes in schedules by Non-Exempt Employees must be within the same FLSA workweek.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Employee Handbook
B. CalOptima Health Policy GA.8018: Paid Time Off
C. Title 29, Code of Federal Regulations (C.F.R.), §778.105
D. 9/80 Worksheet Request Forms (Exempt & Non-Exempt)
E. 9/80 Work Schedule Guidelines

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

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Date	Meeting
06/02/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8020	9/80 Work Schedule	Administrative
Revised	02/01/2014	GA.8020	9/80 Work Schedule	Administrative
Revised	10/01/2014	GA.8020	9/80 Work Schedule	Administrative
Revised	12/01/2016	GA.8020	9/80 Work Schedule	Administrative
Revised	12/03/2020	GA.8020	9/80 Work Schedule	Administrative
Revised	06/02/2022	GA.8020	9/80 Work Schedule	Administrative
Revised		GA.8020	9/80 Work Schedule	Administrative

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IX. GLOSSARY

Term	Definition
9/80 Federal Labor Standards Act (FLSA) Workweek	Under the Fair Labor Standards Act, the workweek is defined as a fixed and regularly recurring period of seven (7) consecutive twenty-four (24) hour periods, or one hundred sixty-eight (168) hours (29 C.F.R. §778.105). The 9/80 workweek begins on the employee's eight (8) hour day, exactly four (4) hours after the scheduled start time and ends exactly three (3) hours and fifty-nine (59) minutes after the scheduled start time on the same day the following week. This is commonly referred to as a "day divide," in which four (4) hours of the eight (8) hour day occurs in one (1) week, and four (4) hours occurs in the following week. Department supervisors/managers and HR can answer questions about day divides.
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks in a pay period. The eight (8) hour workday must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 Work Schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9) hour days and one (1) eight (8) hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9) hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) Workweek.
Exempt Employee	Exempt status is determined by the Human Resources Department based on the position title and duties and responsibilities of the position and consistent with the federal Fair Labor Standards Act (FLSA) regulations. Although an employee's classification may meet applicable federal and/or state exemption criteria, the position may nevertheless be designated as non-exempt. For purposes of this policy, exempt employees do not earn overtime compensation.
Non-Exempt Employee	Non-Exempt status applies to all employees who are not identified by Human Resources as exempt. Non-Exempt employees are paid on an hourly basis and are eligible for overtime compensation. Although an employee's classification may qualify for applicable federal exemptions from the FLSA exemption criteria, the position may nevertheless be designated as non-exempt.
Performance Improvement Plan	A developmental coaching tool used to document performance and behavioral deficiencies or issues and create an action plan with goals and due dates to help employees correct and/or improve performance and behavior while still holding them accountable for past performance.

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Policy:	GA.8032
Title:	**Employee Dress Code**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	06/05/2025
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE ~~☒ Administrative~~

For 2025005 BOD Review Only

I. PURPOSE

This policy ~~sets forth the~~ establishes guidelines ~~CalOptima Health employees shall follow to maintain~~for appropriate workplace attire and grooming ~~at the workplace,~~for all CalOptima Health employees, limited term workers, volunteers, and contractors including those working in the field and remote ~~work~~ locations.

II. POLICY

A. CalOptima Health ~~herein adopts~~maintains a Casual Attire Dress Policy as the standard ~~attire~~ employee dress code during business hours. Employees must ~~choose~~select attire that ~~communicates~~reflects a professional appearance appropriate for the workplace, including ~~the~~ field and remote work locations.

B. ~~There~~Management may ~~be times that management requires~~require employees to ~~dress in~~wear Business Casual Attire or ~~customary~~ Business Professional Attire~~, including, but not limited to, when~~ in certain situations, such as presenting to the Board of Directors, attending ~~a~~ press or public relations ~~event~~events, conducting ~~a~~ job ~~interview~~interviews, meeting with members of the business community, or representing the ~~company~~agency at ~~an outside~~external community ~~function. Employees are to dress appropriately to such~~ functions. When special ~~events and in some cases dress code~~ attire is required, expectations will be communicated to employees in advance.

~~C. All employees are required to sign the Dress Code Acknowledgement Form upon hire.~~

~~D.~~C. The Human Resources (HR) Department will consider reasonable accommodation requests to this policy in accordance with the Fair Employment and Housing Act~~,~~ (FEHA), Americans with Disabilities Act~~,~~ (ADA), Workplace Religious Freedom Act, and ~~any~~ other applicable laws ~~and statutes~~.

~~E.~~D. Department management ~~shall have~~has the discretion to ~~determine~~establish and submit written ~~job duty appropriate~~ attire and grooming requirements appropriate for their employees and independent contractors ~~to~~. Such department dress code requirements must be approved by the HR Department ~~for approval~~.

~~F.~~E. Management is responsible for modeling and ~~monitoring adherence to this policy and may require employees who are out of~~enforcing compliance with this policy. Employees who are not dressed appropriately may be required to take time away from work to correct their ~~dress.~~ attire.

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~~G.~~F. Employees, including management, may be subject to corrective action, up to and including termination, for violations of this ~~Policy~~policy.

III. PROCEDURE

Responsible Party	Action
Employee	~~1. Sign the Dress Code Acknowledgment Form upon hire.~~ ~~2.~~1. Adhere to the requirements outlined in this policy.
Department Manager	1. Model, monitor, and enforce dress and grooming standards ~~in~~within their area of responsibility. 2. ~~If employee attire is~~ Immediately address inappropriate~~, address employee immediately~~ attire when observed. 3. Apply performance management and~~/or administer~~ corrective action ~~when~~as necessary.
Human Resources	~~1.~~ Provide employees with the Dress Code Policy during the onboarding process and ~~Agreement in~~review during the new hire ~~packet.~~ ~~2.~~1. ~~File the Agreement in the employee's personnel file.~~orientation.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. Americans with Disabilities Act
~~B. Dress Code Acknowledgement Form~~
~~C.~~B. Fair Employment and Housing Act
~~D.~~C. Workplace Religious Freedom Act

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

For 20250605 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8032	Employee Dress Code	Administrative
Revised	02/01/2014	GA.8032	Employee Dress Code	Administrative
Revised	11/03/2016	GA.8032	Employee Dress Code	Administrative
Revised	10/04/2018	GA.8032	Employee Dress Code	Administrative
Revised	12/20/2021	GA.8032	Employee Dress Code	Administrative
Revised	05/04/2023	GA.8032	Employee Dress Code	Administrative
Revised	06/05/2025	GA.8032	Employee Dress Code	Administrative

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IX. GLOSSARY

Term	Definition
Business Casual Attire	~~Business Casual Attire includes~~Includes suits, sport coats, dress pants, dress shirts, dress shoes, dress sandals with a backstrap, sweaters, dresses, and skirts. ~~-~~Ties may be worn but are not required. ~~The height of heels~~Heels should ~~be suitable to the individual to prevent safety hazards, and no more than~~not exceed three and one-half (3 1/2) inches ~~in height.~~ for safety reasons. Exclusions from Business Casual Attire ~~follows the same exclusions listed under Casual Attire with the following additional exclusions~~: ▪ Jeans (~~or any type of denim or~~ any color ~~jeans or~~), overalls~~)~~, or denim of any kind ▪ Tennis shoes or canvas shoes
Business Professional Attire	~~Business Professional Attire includes~~Includes collared shirts, ties, two- or three-piece suits, dress pants, ~~dress~~ skirts, blouses, suit dresses, professional accessories, and ~~shoes~~ appropriate ~~to business professional dress~~footwear.
CalOptima Health Logo Attire	~~CalOptima Health Logo Attire includes~~Includes approved sweaters, dress shirts, polo shirts, ~~or~~and other ~~with~~garments featuring CalOptima Health's logo ~~displayed. .~~ Logo attire from any CalOptima Health program is ~~allowed. These shirts can be partnered~~permitted. When paired with dress pants or khaki pants ~~to qualify~~, logo attire qualifies as Business Casual Attire.

For 20250605 BOD Review Only

Term	Definition
Casual Attire	~~Casual Attire includes~~Includes jeans, loose-fitting capri pants (~~loose and~~ below the knee), casual sandals with a backstrap, tennis shoes~~,~~ (in good condition), or ~~other~~similar casual clothing in good condition. ~~-~~Leggings are acceptable only when worn with a dress or long shirt that ~~falls at least~~extends below ~~the~~ mid-thigh ~~level.~~ . Exclusions from Casual Attire ~~does not include~~: ~~▪ T-shirts, including athletic wear, workout shirts, graphic tees, sportswear, concert tees, school or sports team tees, or other types of T-shirts~~ ▪ Athletic wear~~,~~ (including ~~T-shirts, any type of~~ jogging ~~or sweat~~ suits~~/~~, sweatpants, yoga ~~or /~~workout pants) ~~▪ Spaghetti strap tops, casual tank tops, halter tops, or tube tops~~ ▪ Beachwear and casual sandals (such as flip flops, slide sandals) ▪ ~~Any footwear~~Clothing exposing the midriff or other areas inconsistent with a professional environment ▪ Footwear without a back or backstrap ▪ Hats (unless approved by Human Resources) ▪ Ripped, patched, or shredded jeans of any style ▪ See-through clothing ▪ Shorts of any kind ▪ Sleepwear and house slippers ▪ Spaghetti strap tops, tank tops, halter tops, or tube tops ▪ T-shirts, including athletic wear, graphic tees, sportswear/ jerseys, concert tees, school/team T-shirts~~See-through clothing~~ ~~▪ Ripped jeans (including patched or shredded jeans)~~ ~~▪ Any type of shorts~~ ~~▪ Clothing that exposes the midriff area or other parts of the body incompatible with a professional environment~~ ~~▪ Hats, unless prior approval from Human Resources is received~~

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Policy:	GA.8032
Title:	**Employee Dress Code**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	06/05/2025
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 2025 BOD Review Only

I. PURPOSE

This policy establishes guidelines for appropriate workplace attire and grooming for all CalOptima Health employees, limited term workers, volunteers, and contractors including those working in the field and remote locations.

II. POLICY

A. CalOptima Health maintains a Casual Attire Dress Policy as the standard employee dress code during business hours. Employees must select attire that reflects a professional appearance appropriate for the workplace, including field and remote work locations.

B. Management may require employees to wear Business Casual Attire or Business Professional Attire in certain situations, such as presenting to the Board of Directors, attending press or public relations events, conducting job interviews, meeting with members of the business community, or representing the agency at external community functions. When special attire is required, expectations will be communicated to employees in advance.

C. The Human Resources (HR) Department will consider reasonable accommodation requests to this policy in accordance with the Fair Employment and Housing Act (FEHA), Americans with Disabilities Act (ADA), Workplace Religious Freedom Act, and other applicable laws.

D. Department management has the discretion to establish and submit written attire and grooming requirements appropriate for their employees and independent contractors. Such department dress code requirements must be approved by the HR Department.

E. Management is responsible for modeling and enforcing compliance with this policy. Employees who are not dressed appropriately may be required to take time away from work to correct their attire.

F. Employees, including management, may be subject to corrective action, up to and including termination, for violations of this policy.

III. PROCEDURE

Responsible Party	Action
Employee	1. Adhere to the requirements outlined in this policy.

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Responsible Party	Action
Department Manager	1. Model, monitor, and enforce dress and grooming standards within their area of responsibility. 2. Immediately address inappropriate attire when observed. 3. Apply performance management and corrective action as necessary.
Human Resources	1. Provide employees with the Dress Code Policy during the onboarding process and review during the new hire orientation.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. Americans with Disabilities Act
B. Fair Employment and Housing Act
C. Workplace Religious Freedom Act

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8032	Employee Dress Code	Administrative
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Revised	12/20/2021	GA.8032	Employee Dress Code	Administrative
Revised	05/04/2023	GA.8032	Employee Dress Code	Administrative
Revised	06/05/2025	GA.8032	Employee Dress Code	Administrative

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IX. GLOSSARY

Term	Definition
Business Casual Attire	Includes suits, sport coats, dress pants, dress shirts, dress shoes, dress sandals with a backstrap, sweaters, dresses, and skirts. Ties may be worn but are not required. Heels should not exceed three and one-half (3 1/2) inches for safety reasons. Exclusions from Business Casual Attire: ▪ Jeans (any color), overalls, or denim of any kind ▪ Tennis shoes or canvas shoes
Business Professional Attire	Includes collared shirts, ties, two- or three-piece suits, dress pants, skirts, blouses, suit dresses, professional accessories, and appropriate footwear.
CalOptima Health Logo Attire	Includes approved sweaters, dress shirts, polo shirts, and other garments featuring CalOptima Health's logo. Logo attire from any CalOptima Health program is permitted. When paired with dress pants or khaki pants, logo attire qualifies as Business Casual Attire.
Casual Attire	Includes jeans, loose-fitting capri pants (below the knee), casual sandals with a backstrap, tennis shoes (in good condition), or similar casual clothing in good condition. Leggings are acceptable only when worn with a dress or long shirt that extends below mid-thigh. Exclusions from Casual Attire: ▪ Athletic wear (including jogging suits, sweatpants, yoga/workout pants) ▪ Beachwear and casual sandals (such as flip flops, slide sandals) ▪ Clothing exposing the midriff or other areas inconsistent with a professional environment ▪ Footwear without a back or backstrap ▪ Hats (unless approved by Human Resources) ▪ Ripped, patched, or shredded jeans of any style ▪ See-through clothing ▪ Shorts of any kind ▪ Sleepwear and house slippers ▪ Spaghetti strap tops, tank tops, halter tops, or tube tops ▪ T-shirts, including athletic wear, graphic tees, sportswear/ jerseys, concert tees, school/team T-shirts

For 20250605 BOD Review Only

Policy:	GA.8042
Title:	**Supplemental Compensation**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	06/05/2025
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250605 BOD Review Only

I. PURPOSE

This policy establishes general guidelines concerning the use of supplemental compensation above regular base pay to compensate for business needs and to identify items to be reported to CalPERS as "Special Compensation."

II. POLICY

A. CalOptima Health considers the following as Special Compensation pursuant to Title 2, California Code of Regulations (CCR), Section 571:

1. Bilingual Pay/Bilingual Premium;
2. Holiday Premium Pay;
3. Night Shift Premium/Shift Differential;
4. Active Certified Case Manager (CCM) Pay/Educational Incentive; and
5. ~~Executive Incentive Program/Bonus Pay; and~~
6. ~~6.~~5. Temporary Upgrade Pay.

B. Overtime Pay: As a public agency, CalOptima Health follows Federal wage and hour laws. Overtime pay for non-exempt employees will be provided for all time worked in excess of forty (40) in any one (1) federal Fair Labor Standards Act (FLSA) ~~Workweek~~workweek at the rate of one and one half (1.5) times the employee's regular rate of pay, as defined by FLSA. Employees should obtain prior authorization from their supervisors or managers prior to working overtime or incurring overtime pay. Exempt employees are not covered by the overtime provisions and do not receive overtime pay.

C. Holiday Premium Pay: All regular, non-exempt, ~~full-time~~ employees who are eligible for paid holidays but who may be required to work on a holiday observed by CalOptima Health under GA.8056 Paid Holidays will be paid at two (2) times their regular base pay for the hours worked in addition to the holiday pay. Flex Holiday is not eligible for Holiday Premium Pay. This is only

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considered ~~Holiday Pay~~holiday pay pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation for employees who are normally required to work on an approved holiday because they work in positions that require scheduled staffing without regard to holidays.

D. Bilingual Pay: CalOptima Health provides supplemental bilingual pay for qualified exempt and non-exempt employees who are fluent in at least one (1) of CalOptima Health's ~~threshold languages.~~Threshold Languages. This is considered a Bilingual Premium pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate ~~for~~paid to the Bilingual ~~Pay is~~Certified Employee based on the following schedule:

Proficiency	Rate Per Pay Period (Full-Time)	Rate Per Pay Period (Part-Time)
Bilingual language usage with members is required ~~in the job description~~ and used more than fifty percent (50%) of the time in the performance of the employee's job duties.	$60.00	$30.00
Bilingual language usage with members is ~~preferred in the job description~~required and used less than fifty percent (50%) of the time in the performance of the employee's job duties.	$40.00	$20.00

E. Translation Pay: In certain circumstances when, for business reasons and for the benefit of CalOptima Health members, there is a need to translate documents and other written material into languages other than English, the Exempt Employee providing such service will be paid supplemental pay. Non-exempt employees are not eligible for translation pay.

1. Exempt Employees, who do not work in the Cultural & Linguistic Services Department (C&L) and who are not required as part of their regular job responsibilities to translate but are qualified to translate based on successfully passing the CalOptima Health Bilingual Screening Process, may be eligible for translation pay for performing translation work. Eligible employees, who are interested in performing translation work during non-work hours, may elect to provide translation services during their own personal time based on the rates indicated below. The C&L Department shall assign the work to qualified Exempt Employees on an occasional, as-needed basis.

2. There are two (2) key activities in providing translation services:

   a. Translation of materials from English into the desired language, or from another language into English; and

   b. Review and revision of the translation to ensure quality and consistency in usage of terms.

3. Translating is more difficult and time-consuming than reviewing and editing of the already translated materials, and as a result, translation of materials will be reimbursed at a higher rate. CalOptima Health will reimburse for services at the following rates:

   a. Translation – Thirty-five dollars ($35.00) per page; and

   b. Review and revision of translated materials – Twenty-five dollars ($25.00) per page.

4. The use of this supplemental pay is limited to situations where the use of professional translation services is either not available or unfeasible due to business constraints.

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F. Night Shift: CalOptima Health provides supplemental pay for work performed as part of a Night Shift. Assignments for Night Shift are subject to business needs and are at the discretion of CalOptima Health management. This is considered a Shift Differential pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Night Shift is based on the following schedule:

Definition	Eligibility	Rates (per hour)
Night Shift – Seven (7) ~~consecutive~~ hours or more of work between 3 p.m. and 8 a.m.	Non-exempt employees	$2.00 per hour

G. Call Back and On Call: CalOptima Health provides supplemental pay for work performed as part of a Call Back and On Call requirement. Assignments for Call Back and On Call are subject to business needs and are at the discretion of CalOptima Health management. The rates for Call Back and On Call Pay are based on the following schedule:

Definition	Eligibility	Rates (per hour)
Call Back – Employees must physically return to ~~work~~ their worksite within one (1) hour when requested by a Supervisor~~.~~, after their regular shift has ended and they have physically left the workplace . A Supervisor may assign employees other work until the ~~guaranteed~~minimum of four (4) ~~hour time elapses~~hours has elapsed.	All Non-exempt employees	One and one half (1.5) times of regular base pay with a minimum of four (4) hours of pay.
On Call – Employees must remain accessible after normally scheduled work hours and be available to fix problems or report to work, if necessary. Employees will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate, so long as they are fit to respond when called. Employees must respond within one (1) hour, as required.	All Non-exempt employees	$3.00 per hour for being on-call waiting. If a call is taken, employee is on call working and paid one and one half (1.5) times the regular base pay with a thirty (30) minute minimum call.
On Call ~~Medical Case Managers (RN or LVN) and~~ Clinical Pharmacists ~~– Must~~must remain accessible to accept or respond to calls within a reasonable time designated by employee's supervisors. In no event shall employees' supervisors require a response time less than thirty (30) minutes. Employees will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate, so long as they are fit to respond when called.	~~Exempt Employees, excluding those in supervisory positions~~Clinical Pharmacists Only	Twenty five percent (25%) of the employee's base pay as an hourly equivalent multiplied by the number of hours on call.

H. Commuter Allowance: ~~-~~With approval of the Chief Executive Officer (CEO), the Commuter Allowance may be offered each fiscal year to provide an amount of one hundred fifty dollars ($150.00) per pay period to ~~full-time employees~~Full-Time Employees designated as Full Office Workers, and seventy-five dollars ($75.00) per pay period to ~~full-time employees~~Full-Time Employees designated as Partial Teleworkers. ~~The~~ For new hires, the Commuter Allowance begins with the first ~~full~~ pay period of their employment. For changes to telework status, any resulting change to the Commuter Allowance begins the first Full Pay Period as a Full Office Worker or

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Partial Teleworker. Eligible ~~full-time employees~~Full-Time Employees will continue to receive the Commuter Allowance until the first ~~full pay period~~Full Pay Period in which an employee is not assigned to partial telework or full office work. The Commuter Allowance will be provided only for ~~full pay periods~~Full Pay Periods in which employees are designated a Full Office Worker or Partial Teleworker and will not be prorated for being designated as a Full Office Worker or Partial Teleworker for a portion of the pay period. Executive Level Positions and Full Teleworkers are not eligible for the Commuter Allowance. The Commuter Allowance may be paused and resumed at the discretion of the CEO.

I. Internet Stipend: CalOptima Health shall provide an Internet Stipend in the amount of twenty-five dollars ($25.00) per pay period to ~~full-time employees~~Full-Time Employees and eighteen dollars seventy-five cents ($18.75) to Part-Time Employees designated as Full Teleworkers, Partial Teleworkers or Community Workers. The Internet Stipend begins the first ~~full pay period~~Full Pay Period as a Full or Partial Teleworker or Community Worker. Eligible ~~full-time employees~~Full-Time Employees will continue to receive the stipend until the first, ~~full pay period~~Full Pay Period in which an employee is not assigned to full or partial telework or community work. The Internet Stipend will be provided only for ~~full pay periods~~Full Pay Periods and will not be prorated for a change in designation for a portion of a pay period. Executive Level Positions and Full Office Workers are not eligible for the Internet Stipend.

J. Active Certified Case Manager (CCM) Pay: CalOptima Health may recognize supplemental pay of one hundred dollars ($100.00) per pay period to an ~~RN~~employee who holds an active CCM certification when such certification is required or preferred in the job description and used regularly in performance of the employee's job duties. This will not be prorated for partial pay periods. This is considered as an Educational Incentive pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation.

K. Executive Incentive ~~Program:~~ Plan: The Chief Executive Officer (CEO) may recognize Executive Level Positions, including interim appointments, using incentive ~~compensation as described in this Policy. For~~pay for employees in Executive Level Positions who achieve outstanding performance~~,~~. Detailed elements of this program are available in the ~~incentive compensation is considered bonus pay pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation for CalPERS Classic Members.~~CalOptima Health Executive Incentive Plan Guidelines.

L. Employee Sales and Enrollment Incentive Program. Changes to this plan will be effective July 1, 2024. The purpose of the Program is to provide incentives for qualified and eligible staff whose primary job responsibility is to enroll new members in CalOptima Health's competitive programs, OneCare, and Program for All-Inclusive Care for the Elderly (PACE). Employees eligible for the Program must be employed by CalOptima Health, in good standing. Eligible employees must also individually sign a Sales and Enrollment Incentive Program Agreement, which does not alter the at-will nature of their relationship with CalOptima Health. The Sales and Enrollment Incentive Program may be modified or withdrawn, at any time, with five days' advance written notice.

1. OneCare Program: The Director I, Sales and Marketing; OneCare Manager Member Outreach and Education; OneCare Supervisor Member Outreach and Education; OneCare Community Partner and Community Partner Sr; and OneCare Community Partner Inside Sales staff in the Marketing and Sales Department must have an active Resident Insurance Producer license to enroll eligible members into the OneCare program. These licensed employees may be eligible to receive an incentive payment based on the number of new enrollments produced and retained in the OneCare program on a monthly basis in accordance with the OneCare Sales and Enrollment Incentive Program Agreement signed by each eligible employee.

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2. PACE Program: The Supervisor Member Outreach and Education and Enrollment Coordinators staff are eligible for the Sales and Enrollment Incentive Program and may receive incentive payments based on the number of new enrollments produced and retained in the PACE Program on a monthly basis in accordance with the PACE Sales and Enrollment Incentive Program Agreement signed by each eligible employee.

M. Employee Incentive Program: At the discretion of the CEO, specific employees may be recognized through incentive compensation, when doing so is consistent with CalOptima Health's business needs and mission, vision, and values.

N. Retention Incentive: In order to preserve organizational talent and to maintain business continuity when the loss of key personnel may cause risk or damage to operational efficiency, regulatory compliance, and/or strategic imperatives, CalOptima Health may, at the discretion of the CEO, and on an ~~exception~~exceptional basis, award a retention incentive.

O. Recruitment Incentive: At the discretion of the CEO, a recruitment incentive of up to fifteen percent (15%) of the midpoint of base pay for the applicable position may be offered to entice an individual to join CalOptima Health. Recruitment incentives of up to a maximum of fifty thousand dollars ($50,000) may be offered for Executive Level Positions and require informing the Board of Directors after ~~approved~~approval.

P. Incentive programs may be modified or withdrawn, at any time. An award of incentive compensation is entirely at the discretion of the CEO and/or Board of Directors, as applicable. ~~It~~An award of incentive compensation in one (1) year is not ~~intended to be a binding contract between Executive Level Positions~~indicative or ~~employees~~a guarantee of future awards of incentive compensation and does not alter the at-will nature of employment at CalOptima Health.

Q. Employer-Paid Member Contribution (EPMC): CalOptima Health contributes seven percent (7%) of ~~compensation earnable~~Compensation Earnable, on behalf of eligible employees who hold ~~management staff~~Management Staff positions as identified in the CalOptima Health salary schedule, and who qualify based on all of the following:

1. Hired, promoted, or transferred into a ~~management staff~~Management Staff position, including interim appointments; and

2. Included in one (1) of the following categories:

   a. A CalPERS Classic Member; or

   b. A member prior to January 1, 2013, of another California public retirement system that is eligible for reciprocity with CalPERS.

R. Annual Performance Lump Sum Bonus: Employees paid at or above the pay range maximum are not eligible for future base pay increases. As a result, in lieu of future base pay increases, these employees may be eligible for merit ~~bonus pay~~Bonus Pay delivered as a lump sum bonus in accordance with Section III.N. of this Policy, provided that their performance meets the goals and objectives set forth by their managers.

S. Automobile Allowance: CalOptima Health may, at the discretion of the CEO, provide employees in Executive Level Positions, including interim appointments, with a monthly automobile allowance in an amount not to exceed five hundred dollars ($500.00) for the use of their personal vehicle for CalOptima Health business.

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T. Supplemental Retirement Benefit: Consistent with applicable Board actions, the CEO is authorized to determine CalOptima Health's contribution rate for employees to ~~the~~a 401(a) tax-qualified supplemental retirement benefit (SRB) plan ~~administered by the Public Agency Retirement System (PARS)~~ within the limits of the budget and subject to contribution limits established by applicable laws. With the exception of employees in Executive Level Positions, the contribution rate shall be uniform for all employees. Executive Level Positions will also receive the same uniform contribution rate applicable to all employees. However, for employees in Executive Level Positions who earn more than the applicable compensation limits, the CEO is authorized to provide additional supplemental contributions to ~~PARS~~the 401(a) SRB plan, subject to the limitations of applicable laws. An employee in an Executive Level Position must still be employed by CalOptima Health at the time the additional supplemental contribution ~~to PARS~~ is distributed in order to be eligible to earn and receive the additional supplemental contributions. ~~These SRB contributions to~~Government Code Sections 7522.72 and 7522.74 require the ~~PARS~~forfeiture of all accrued rights and benefits in any public retirement ~~plan shall continue from year to year, unless otherwise adjusted or discontinued.~~system by any public employee convicted of any job-related felony, as of the earliest date of the crime.

U. Work Life Balance Stipend: CalOptima Health shall provide an annual Work Life Balance Stipend of five hundred dollars ($500.00) to ~~full-time employees~~Full-Time Employees and two hundred fifty dollars ($250.00) to ~~part-time employees~~Part-Time Employees. The stipend is intended to promote employee wellness through enhanced work life balance and may be used for any wellness-related purchases, such as dependent care, gym memberships, yoga classes, art therapy, dietician services, athletic gear, personal development courses, and more. The stipend is taxable and paid in two (2) increments of two hundred fifty dollars ($250.00) to ~~full-time employees~~Full-Time Employees and one hundred twenty-five dollars ($125.00) to ~~part-time employees~~Part-Time Employees on the pay periods that include November 01, and May 01 each year.

V. Benefit Income: CalOptima Health shall provide a bi-monthly taxable medical stipend as a cost savings measure to CalOptima Health and incentive for employees who have medical coverage outside of CalOptima Health. Employees must submit proof of outside coverage in order to be eligible for this benefit. The amount of the bi-monthly stipend is approved by the Board of Directors on an annual basis.

W. Temporary Upgrade Pay: An employee who is appointed for a limited duration to a job having a higher pay grade is eligible for Temporary Upgrade Pay. The employee must meet the minimum requirements of the position and be performing all essential job functions and responsibilities of the upgraded position without performing duties of their current job to qualify for Temporary Upgrade Pay. Temporary Upgrade Pay will be the minimum of the new pay rate or a five percent (5%) of base pay increase, whichever is greater. Temporary Upgrade Pay will be eliminated when the temporary assignment ends. The temporary assignment shall not exceed nine hundred and sixty (960) hours. Temporary Upgrade Pay is considered premium pay pursuant to Title 2 CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation for CalPERS Classic Members~~.~~ only.

III. PROCEDURE

A. Overtime Pay: Overtime must be approved in advance by an employee's manager. Adjustments for overtime pay cannot be calculated until the completion of an employee's workweek. This may result in one (1) pay period's delay in the employee receiving the additional compensation.

B. Holiday Premium Pay: Working on a CalOptima Health observed holiday must be approved in advance by the employee's manager. Unauthorized work that occurs on an observed holiday is not

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eligible for Holiday Premium Pay and will be paid at the employee's regular base pay. Actual hours worked on a holiday will be used for purposes of calculating overtime.

C. Bilingual Pay: An employee or potential employee shall undergo a written and verbal ~~bilingual~~language fluency evaluation when bilingual proficiency is a required part of the employee's or potential employee's job ~~description~~ and used in the performance of the employee's job duties with members. If the employee or potential employee passes the evaluations, bilingual pay shall be established. For new hires, the Bilingual Pay begins with the first pay period of their employment. Changes to Bilingual Pay will occur at the start of a pay period. Bilingual pay shall not be prorated. Temporary and/or interim assignments will not impact bilingual pay.

D. Translation Pay: If an eligible ~~exempt employee~~Exempt Employee elects to provide translation services, and such services are not part of the employee's regular job duties, the employee shall submit their interest to the C&L Department. If selected, the translation pay identified above will be provided depending on the variables noted above, taking into account whether professional translation services are either not available or unfeasible due to business constraints.

E. Night Shift:

1. Night Shift differential is automatically calculated for those employees regularly working a night shift, defined as seven (7) ~~consecutive~~ hours or more of work between 3:00 p.m. and 8:00 a.m.

2. Employees who, at their own request and for their own convenience, adjust their work schedule, such as requesting make up time or alternative hours, and as a result, would be eligible for night shift pay, shall be deemed as having waived their right to same. When appropriate, a new Action Form should be submitted, removing the employee from the night shift.

F. Call Back and On Call Pay:

1. If employees are on call or get called back to work, the employees are responsible for adding this time to their schedules through CalOptima Health's time keeping system, which is then approved by their supervisors.

G. Commuter Allowance~~:~~:

1. Commuter Allowance is automatically calculated for eligible employees based on system designation of Full Office Worker or Partial Teleworker. Employees and leaders are responsible for maintaining accurate designations in the timekeeping system. Designation changes require a request and approval per the Telework Program Guidelines. CalOptima Health may periodically audit and validate employee Office/Telework designations.

H. Internet Stipend:

1. Internet Stipend is automatically calculated for eligible employees based on system designation of Full Teleworker, Partial Teleworker, or Community Worker. Employees and leaders are responsible for maintaining accurate designations in the timekeeping system. Telework designation changes require a request and approval per the Telework Program Guidelines. Community Worker designation is determined by the position. CalOptima Health may periodically audit and validate employee Office/Telework designations.

I. Active Certified Case Manager (CCM) Pay:

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1. To receive CCM supplemental pay, an employee is responsible for providing a copy of the employee's case management certification issued by the Case Management Society of America to the Human Resources Department. Temporary and/or interim assignments will not impact CCM pay.

J. ~~Incentive Compensation~~ Executive Incentive Plan

1. The Board of Directors approves CalOptima Health's strategic plan for each fiscal year, and the CEO is expected to meet the goals set forth in the strategic plan. The CEO in turn sets goals for the Executive Level Positions. CalOptima Health's Executive Incentive Pay Plan will be administered in accordance with the CalOptima Health Executive Incentive Plan Guidelines.

~~1. The CEO may establish an incentive compensation program for Executive Level Positions based on the Executive Incentive Program attached within budgeted parameters in accomplishing specific results according to the department and individual goals set forth by the CEO and the level of achievement. Executive Level Positions will receive a performance evaluation based on the Performance Review of Executives Template attached, which measures their performance against the established goals. Based on the level of performance, the executive staff member may be eligible for a lump sum bonus payment. The executive staff member must still be employed by CalOptima Health and in good standing at the time the bonus is distributed in order to be eligible to receive the bonus payment. For eligible Executive Level Positions who achieve outstanding performance, CalOptima Health will report the bonus payment to CalPERS as Special Compensation. The CEO is authorized to make minor revisions to the Executive Incentive Program and Performance Review of Executives Template from time to time, as appropriate.~~

~~2. As circumstances warrant and at the discretion of the CEO, employees not in Executive Level Positions, whose accomplishments have provided extraordinary results, may be considered for incentive compensation.~~

K. Employee Sales and Enrollment Incentive Program:

1. The Executive Director, Medicare Programs or designee will review the Employee Sales and Enrollment Incentive structure for the OneCare and PACE Programs on an annual basis and will submit any required changes to the incentive structure and the OneCare and PACE Employee Sales and Enrollment Incentive Agreements for review and approval by the CEO, or designee.

2. OneCare:

a. Employees with the job titles of Director I, Sales and Marketing, OneCare Manager Member Outreach and Education; Supervisor Member Outreach and Education; OneCare Community Partner and Community Partner Sr and OneCare Community Partner Inside Sales are eligible for the Sales and Enrollment Incentive Program and will be required to sign a OneCare Sales and Enrollment Incentive Agreement on an annual basis, which may include revisions to the incentive structure or enrollment goals specific each eligible employee job title.

b. The OneCare Manager Outreach and Education will be responsible for calculating monthly payments for employees who are eligible for the OneCare Sales and Enrollment Incentive Program based on the number of enrollments produced each month according to the terms of the OneCare Sales and Enrollment Incentive Agreement effective at the time the enrollments are produced. The Manager will submit a detailed report of enrollments

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produced and payments due for approval by the Executive Director, Medicare Programs, and the Chief Financial Officer.

3. PACE:

   a. Employees with the job titles of PACE Supervisor Member Outreach and Education and PACE Enrollment Coordinator are eligible for the Sales and Enrollment Incentive Program and will be required to sign a PACE Sales Incentive Agreement on an annual basis, which may include revisions to the incentive structure or enrollment goals specific to their job title.

   b. The PACE Manager Marketing & Enrollment will be responsible for calculating monthly incentive payments for employees who are eligible for the PACE Sales and Enrollment Incentive Program based on the number of enrollments produced each month according to the terms of the PACE Sales and Enrollment Incentive Program Agreement effective at the time the enrollments are produced. The Manager will submit a detailed report of enrollments produced and payments due for approval by the Executive Director, Medicare Programs, and the Chief Financial Officer.

L. Retention Incentive: As circumstances warrant, the CEO may award an employee a retention incentive to prevent or delay departures that may adversely impact business operations. The employee offered a retention incentive must be in good standing and accept and sign a retention agreement which contains the condition(s) to be met to receive payment. Payment of the incentive will be made when the terms of the agreement have been fully met and at the conclusion of the retention period. The CEO has the authority to offer retention incentives for up to twenty-five (25) employees per fiscal year in an amount not to exceed twenty percent (20%) of the employee's current base annual salary. Retention incentives that exceed twenty percent (20%) of the employee's current base annual salary require Board of Directors' approval.

M. Recruitment Incentive: As circumstances warrant, the CEO may offer a recruitment incentive based on the Compensation Administration Guidelines managed by the Human Resources Department to entice an individual to join CalOptima Health. Recruitment incentives of up to a maximum of fifty thousand dollars ($50,000) may be offered for Executive Level Positions and require informing the Board of Directors after approved. To receive the recruitment incentive, the individual offered the incentive is required to accept and sign an offer letter which contains a "claw-back" provision obligating the recipient of a recruitment incentive to return the full amount of the recruitment incentive if the recipient voluntarily terminates employment with CalOptima Health within twenty-four (24) months of the date of hire.

N. Annual Performance Lump Sum Bonus: Once employees have reached the pay range maximum, employees may be eligible for merit ~~bonus pay~~Bonus Pay delivered as a lump sum bonus, provided that their annual performance evaluations meet the established goals and objectives set forth by their managers. Merit ~~bonus pay~~Bonus Pay will not exceed the maximum percentage of the merit increase matrix and reflects employees' superior performance measured against established objectives. Annual performance lump sum bonuses are paid out in two (2) incremental amounts – the first half when merit salary increases are normally distributed and the second half six (6) months later. The employee must still be employed by CalOptima Health to be eligible to earn and receive the lump sum bonus payments.

O. Automobile Allowance: As circumstances warrant, the CEO may offer employees in Executive Level Positions an automobile allowance in lieu of the IRS standard mileage reimbursement rate that would otherwise apply for the use of their personal vehicle in the performance of their duties. Such automobile allowance will be identified on the employees' W-2 forms as taxable income. In

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addition, as a condition of receiving such allowance, the employee must comply with the following requirements:

1. Maintain adequate levels of personal vehicle insurance coverage;

2. Purchase their own fuel for the vehicle; and

3. Ensure the vehicle is properly maintained.

P. Work Life Balance Stipend: Work Life Balance Stipend is automatically calculated for eligible employees. To be eligible, employees must be in active status (either working or on a paid LOA) in the pay period that includes May 1 or November 1. Employees on an approved, unpaid LOA when the Work Life Balance Stipend is paid will receive a retroactive payment upon return to active status.

Q. Benefit Income: Once enrolled in Benefit Income, the participating employee's election to waive CalOptima Health medical insurance will remain in effect for the entire, or remaining, plan year (January 1 through December 31) unless the employee has a qualifying event. Benefit Income may be temporarily suspended for employees who are on an approved leave of Absence (LOA) without pay in accordance with CalOptima Health Policies GA.8039: Pregnancy Disability Leave and Related Workplace Accommodation, GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence, GA.8041: Workers' Compensation Program, or GA.8063: Disability Accommodations. However, retroactive payment for Benefit Income will be applied for the period of protected, unpaid leave upon return to active duty.

R. Temporary Upgrade Pay: Human Resources will calculate Temporary Upgrade Pay for eligible employees who are authorized and appointed for a limited duration to assume the duties of a position with a higher pay grade.

~~**IV. ATTACHMENT(S)**~~

~~A. Executive Incentive Program~~
~~A. Performance Review of Executives Template~~

S. Supplemental Compensation During Leave of Absence: An employee on a Continuous LOA is not eligible to receive certain supplemental compensation, such as Bilingual Pay, Night Shift Premium, Call Back or On Call Pay, Active Certified Case Manager (CCM) Pay, Internet Stipend, Commuter Allowance, or Automobile Allowance during their LOA. If applicable, an employee on a Continuous LOA may be eligible for Employer-Paid Member Contribution, Supplemental Retirement Benefit and Benefit Income during any portion of a paid LOA but shall not be eligible if the LOA is unpaid. Executive incentives will be prorated to account for an executive's Personal LOA time period. Executives must be current employees during the pay period the executive incentive is paid for eligibility. Supplemental compensation will resume when the employee returns to an active status, and may be prorated, where applicable.

T. Proration: For supplemental compensation that is paid per pay period and not based on hourly pay rate (i.e. Bilingual Pay, Active Certified Case Manager, Internet Stipend, Commuter Allowance, Automobile Allowance, and Benefit Income), such compensation will begin the first Full Pay Period after eligibility is established. These items of compensation will be provided only for Full Pay Periods and will not be prorated for a change in eligibility for a portion of the pay period.

U. Supplemental Compensation for Part-Time Employees

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1. If eligible, regular Part-Time Employees will receive pro-rated supplemental compensation based on their approved work schedule, as reflected in the timekeeping system, for the following:

   a. Active Certified Case Manager Pay / Educational Incentive;

   b. Executive Incentive Pay Plan;

   c. Annual Merit Lump Sum Bonus;

   d. Automobile Allowance; and

   e. Benefit Income.

2. Exceptions include the following:

   a. Bilingual Pay, Internet Stipend and Work Life Balance Stipends will be paid in accordance with Section II.

V. Part-Time Employees are not eligible for the Commuter Allowance.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Employee Handbook
B. CalOptima Health Executive Incentive Plan Guidelines
C. CalOptima Health Performance Review of Executives Template
D. CalOptima Health Policy GA.8039: Pregnancy Disability Leave and Related Workplace Accommodation
E. CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence
F. CalOptima Health Policy GA.8041: Workers' Compensation Program
G. CalOptima Health Policy GA.8056: Paid Holidays
H. CalOptima Health Policy GA.8063: Disability Accommodations
~~B.~~I. Compensation Administration Guidelines
~~C.~~J. Government Code, §20636 and 20636.1
~~D.A. Telework Program Guidelines~~
~~E.A. Title 2, California Code of Regulations (CCR), §571~~
~~F.~~K. PACE Sales and Enrollment Incentive Program Agreement: Supervisor Member Outreach and Education
~~G.A. PACE Sales and Enrollment Incentive Program Agreement: Enrollment Coordinator~~
~~H.~~L. OneCare Sales and Enrollment Incentive Program Agreement: Community Partner and Community Partner Sr
M. OneCare Sales and Enrollment Incentive Program Agreement: Community Partner Inside Sales
~~I.~~N. OneCare Sales and Enrollment Incentive Program Agreement: Supervisor Member Outreach and Education
O. OneCare Sales and Enrollment Incentive Program Agreement: Manager Member Outreach & Education
P. OneCare Sales and Enrollment Incentive Program Agreement: Director I, Sales and Marketing
Q. PACE Sales and Enrollment Incentive Program Agreement: Enrollment Coordinator

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R. Telework Program Guidelines
S. Title 2, California Code of Regulations (CCR), §571

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
12/07/2023	Regular Meeting of the CalOptima Health Board of Directors
06/06/2024	Regular Meeting of the CalOptima Health Board of Directors
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8042	Pay Differentials	Administrative
Revised	05/20/2014	GA.8042	Supplemental Compensation	Administrative
Revised	12/03/2015	GA.8042	Supplemental Compensation	Administrative
Revised	09/07/2017	GA.8042	Supplemental Compensation	Administrative
Revised	06/07/2018	GA.8042	Supplemental Compensation	Administrative
Revised	02/07/2019	GA.8042	Supplemental Compensation	Administrative
Revised	04/02/2020	GA.8042	Supplemental Compensation	Administrative
Revised	04/07/2022	GA.8042	Supplemental Compensation	Administrative
Revised	06/02/2022	GA.8042	Supplemental Compensation	Administrative
Revised	05/04/2023	GA.8042	Supplemental Compensation	Administrative
Revised	12/07/2023	GA.8042	Supplemental Compensation	Administrative
Revised	06/06/2024	GA.8042	Supplemental Compensation	Administrative
Revised	06/05/2025	GA.8042	Supplemental Compensation	Administrative

For

IX. GLOSSARY

Term	Definition
Bilingual Certified Employee	An employee who has passed CalOptima Health's Bilingual Screening Process either upon hire or any time during their employment.
Bilingual Screening Process	Prospective staff translators are identified by the Cultural and Linguistic (C&L) Services Department based on qualifications obtained through CalOptima Health's bilingual screening process. The screening is either conducted as part of their initial hiring process or later during their employment. All staff translators must possess a strong ability to read, write and understand the target language. Once identified as potential staff translators, they are required to take a proficiency test created by the C&L Services Department. They are evaluated on their vocabulary, grammar, orthography, flow, accuracy, cultural sensitivity, as well as consistency in usage of translated terms. The selection is based on their overall score.
Bonus Pay	Compensation to employees for superior performance such as "annual performance bonus" and "merit pay." If provided only during a member's final compensation period, it shall be excluded from final compensation as "final settlement" pay. A program or system must be in place to plan and identify performance goals and objectives to count as Special Compensation for CalPERS purposes.
CalPERS ~~CalPERS Classic Director~~	California Public Employees Retirement System ~~A Management Staff who is either a CalPERS Classic Member or a member prior to January 1, 2013, of another California public retirement system who is eligible for reciprocity with CalPERS.~~
CalPERS Classic ~~CalPERS Classic Executive~~ Member	A member enrolled in CalPERS prior to January 1, 2013. ~~An Executive Staff who is either a CalPERS Classic Member or a member prior to January 1, 2013, of another California public retirement system who is eligible for reciprocity with CalPERS.~~
Community Worker ~~Central Worksite~~	An employee in a position that performs fifty-one percent (51%) or more of their duties in field locations such as provider offices, members' homes, and at community outreach events. ~~CalOptima Health's primary physical location of business applicable to the employee, which is either CalOptima Health's administration building at 505 City Parkway West, the PACE building or other CalOptima Health operated location.~~
Compensation Earnable	The pay rate and Special Compensation as defined in Government Code sections 20636 and 20636.1.
Continuous Leave of Absence (LOA)	Leave that is taken uninterruptedly, rather than intermittently.
Executive Level Position	The position of Executive Director or above.
Exempt Employee	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Full Pay Period	A Full Pay Period refers to all of an employee's scheduled work hours within a pay period.
Full Office Worker	An employee who is assigned to work their full schedule at the Central Worksite.

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Term	Definition
Full Teleworker	An eligible employee who is approved to routinely work their entire regularly scheduled work hours from a Remote Work Location unless business needs require otherwise.
Full-Time Employees	For purposes of this policy, employees who are regularly scheduled to work thirty (30) hours or more per week.
Leave of Absence (LOA)	A term used to describe an authorized period of time off longer than five (5) days that an employee is to be away from their primary job, while maintaining the status of employee.
Management Staff	Staff holding positions at or above Director level.
Partial Teleworker	An eligible employee who is approved to work a pre-established consistent weekly work schedule split between two (2) or more full days per week at the Central Worksite, and the remainder of full days at the Remote Work Location.
Part-Time Employees	Employees who are regularly scheduled to work less than thirty (30) hours per week.
Sales Incentive	An amount of money paid, in addition to base pay, to an employee for successfully enrolling a member into the OneCare Program.
Special Compensation	Payment of additional compensation earned separate from an employee's base pay that meets the criteria listed in Title 2, California Code of Regulations (CCR) section 571(a).
Threshold Language	~~For purposes of this policy, a~~ A threshold language as defined by the Centers for Medicare & Medicaid Services (CMS) for Medicare programs, or Department of Health Care Services for the Medi-Cal program.

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Policy:	GA.8042
Title:	**Supplemental Compensation**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	06/05/2025
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy establishes general guidelines concerning the use of supplemental compensation above regular base pay to compensate for business needs and to identify items to be reported to CalPERS as "Special Compensation."

II. POLICY

A. CalOptima Health considers the following as Special Compensation pursuant to Title 2, California Code of Regulations (CCR), Section 571:

1. Bilingual Pay/Bilingual Premium;
2. Holiday Premium Pay;
3. Night Shift Premium/Shift Differential;
4. Active Certified Case Manager (CCM) Pay/Educational Incentive; and
5. Temporary Upgrade Pay.

B. Overtime Pay: As a public agency, CalOptima Health follows Federal wage and hour laws. Overtime pay for non-exempt employees will be provided for all time worked in excess of forty (40) in any one (1) federal Fair Labor Standards Act (FLSA) workweek at the rate of one and one half (1.5) times the employee's regular rate of pay, as defined by FLSA. Employees should obtain prior authorization from their supervisors or managers prior to working overtime or incurring overtime pay. Exempt employees are not covered by the overtime provisions and do not receive overtime pay.

C. Holiday Premium Pay: All regular, non-exempt, employees who are eligible for paid holidays but who may be required to work on a holiday observed by CalOptima Health under GA.8056 Paid Holidays will be paid at two (2) times their regular base pay for the hours worked in addition to the holiday pay. Flex Holiday is not eligible for Holiday Premium Pay. This is only considered holiday pay pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special

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Compensation for employees who are normally required to work on an approved holiday because they work in positions that require scheduled staffing without regard to holidays.

D. Bilingual Pay: CalOptima Health provides supplemental bilingual pay for qualified exempt and non-exempt employees who are fluent in at least one (1) of CalOptima Health's Threshold Languages. This is considered a Bilingual Premium pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate paid to the Bilingual Certified Employee based on the following schedule:

Proficiency	Rate Per Pay Period (Full-Time)	Rate Per Pay Period (Part-Time)
Bilingual language usage with members is required and used more than fifty percent (50%) of the time in the performance of the employee's job duties.	$60.00	$30.00
Bilingual language usage with members is required and used less than fifty percent (50%) of the time in the performance of the employee's job duties.	$40.00	$20.00

E. Translation Pay: In certain circumstances when, for business reasons and for the benefit of CalOptima Health members, there is a need to translate documents and other written material into languages other than English, the Exempt Employee providing such service will be paid supplemental pay. Non-exempt employees are not eligible for translation pay.

1. Exempt Employees, who do not work in the Cultural & Linguistic Services Department (C&L) and who are not required as part of their regular job responsibilities to translate but are qualified to translate based on successfully passing the CalOptima Health Bilingual Screening Process, may be eligible for translation pay for performing translation work. Eligible employees, who are interested in performing translation work during non-work hours, may elect to provide translation services during their own personal time based on the rates indicated below. The C&L Department shall assign the work to qualified Exempt Employees on an occasional, as-needed basis.

2. There are two (2) key activities in providing translation services:

   a. Translation of materials from English into the desired language, or from another language into English; and

   b. Review and revision of the translation to ensure quality and consistency in usage of terms.

3. Translating is more difficult and time-consuming than reviewing and editing of the already translated materials, and as a result, translation of materials will be reimbursed at a higher rate. CalOptima Health will reimburse for services at the following rates:

   a. Translation – Thirty-five dollars ($35.00) per page; and

   b. Review and revision of translated materials – Twenty-five dollars ($25.00) per page.

4. The use of this supplemental pay is limited to situations where the use of professional translation services is either not available or unfeasible due to business constraints.

F. Night Shift: CalOptima Health provides supplemental pay for work performed as part of a Night Shift. Assignments for Night Shift are subject to business needs and are at the discretion of

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CalOptima Health management. This is considered a Shift Differential pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Night Shift is based on the following schedule:

Definition	Eligibility	Rates (per hour)
Night Shift – Seven (7) hours or more of work between 3 p.m. and 8 a.m.	Non-exempt employees	$2.00 per hour

G. Call Back and On Call: CalOptima Health provides supplemental pay for work performed as part of a Call Back and On Call requirement. Assignments for Call Back and On Call are subject to business needs and are at the discretion of CalOptima Health management. The rates for Call Back and On Call Pay are based on the following schedule:

Definition	Eligibility	Rates (per hour)
Call Back – Employees must physically return to their worksite within one (1) hour when requested by a Supervisor, after their regular shift has ended and they have physically left the workplace . A Supervisor may assign employees other work until the minimum of four (4) hours has elapsed.	All Non-exempt employees	One and one half (1.5) times of regular base pay with a minimum of four (4) hours of pay.
On Call – Employees must remain accessible after normally scheduled work hours and be available to fix problems or report to work, if necessary. Employees will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate, so long as they are fit to respond when called. Employees must respond within one (1) hour, as required.	All Non-exempt employees	$3.00 per hour for being on-call waiting. If a call is taken, employee is on call working and paid one and one half (1.5) times the regular base pay with a thirty (30) minute minimum call.
On Call - Clinical Pharmacists must remain accessible to accept or respond to calls within a reasonable time designated by employee's supervisors. In no event shall employees' supervisors require a response time less than thirty (30) minutes. Employees will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate, so long as they are fit to respond when called.	Clinical Pharmacists Only	Twenty five percent (25%) of the employee's base pay as an hourly equivalent multiplied by the number of hours on call.

H. Commuter Allowance: With approval of the Chief Executive Officer (CEO), the Commuter Allowance may be offered each fiscal year to provide an amount of one hundred fifty dollars ($150.00) per pay period to Full-Time Employees designated as Full Office Workers, and seventy-five dollars ($75.00) per pay period to Full-Time Employees designated as Partial Teleworkers. For new hires, the Commuter Allowance begins with the first pay period of their employment. For changes to telework status, any resulting change to the Commuter Allowance begins the first Full Pay Period as a Full Office Worker or Partial Teleworker. Eligible Full-Time Employees will continue to receive the Commuter Allowance until the first Full Pay Period in which an employee is not assigned to partial telework or full office work. The Commuter Allowance will be provided only for Full Pay Periods in which employees are designated a Full Office Worker or Partial Teleworker and will not be prorated for being designated as a Full Office Worker or Partial Teleworker for a portion of the pay period. Executive Level Positions and Full Teleworkers are not eligible for the

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Commuter Allowance. The Commuter Allowance may be paused and resumed at the discretion of the CEO.

I. Internet Stipend: CalOptima Health shall provide an Internet Stipend in the amount of twenty-five dollars ($25.00) per pay period to Full-Time Employees and eighteen dollars seventy-five cents ($18.75) to Part-Time Employees designated as Full Teleworkers, Partial Teleworkers or Community Workers. The Internet Stipend begins the first Full Pay Period as a Full or Partial Teleworker or Community Worker. Eligible Full-Time Employees will continue to receive the stipend until the first, Full Pay Period in which an employee is not assigned to full or partial telework or community work. The Internet Stipend will be provided only for Full Pay Periods and will not be prorated for a change in designation for a portion of a pay period. Executive Level Positions and Full Office Workers are not eligible for the Internet Stipend.

J. Active Certified Case Manager (CCM) Pay: CalOptima Health may recognize supplemental pay of one hundred dollars ($100.00) per pay period to an employee who holds an active CCM certification when such certification is required or preferred in the job description and used regularly in performance of the employee's job duties. This will not be prorated for partial pay periods. This is considered as an Educational Incentive pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation.

K. Executive Incentive Plan: The Chief Executive Officer (CEO) may recognize Executive Level Positions, including interim appointments, using incentive pay for employees in Executive Level Positions who achieve outstanding performance. Detailed elements of this program are available in the CalOptima Health Executive Incentive Plan Guidelines.

L. Employee Sales and Enrollment Incentive Program. Changes to this plan will be effective July 1, 2024. The purpose of the Program is to provide incentives for qualified and eligible staff whose primary job responsibility is to enroll new members in CalOptima Health's competitive programs, OneCare, and Program for All-Inclusive Care for the Elderly (PACE). Employees eligible for the Program must be employed by CalOptima Health, in good standing. Eligible employees must also individually sign a Sales and Enrollment Incentive Program Agreement, which does not alter the at-will nature of their relationship with CalOptima Health. The Sales and Enrollment Incentive Program may be modified or withdrawn, at any time, with five days' advance written notice.

1. OneCare Program: The Director I, Sales and Marketing; OneCare Manager Member Outreach and Education; OneCare Supervisor Member Outreach and Education; OneCare Community Partner and Community Partner Sr; and OneCare Community Partner Inside Sales staff in the Marketing and Sales Department must have an active Resident Insurance Producer license to enroll eligible members into the OneCare program. These licensed employees may be eligible to receive an incentive payment based on the number of new enrollments produced and retained in the OneCare program on a monthly basis in accordance with the OneCare Sales and Enrollment Incentive Program Agreement signed by each eligible employee.

2. PACE Program: The Supervisor Member Outreach and Education and Enrollment Coordinators staff are eligible for the Sales and Enrollment Incentive Program and may receive incentive payments based on the number of new enrollments produced and retained in the PACE Program on a monthly basis in accordance with the PACE Sales and Enrollment Incentive Program Agreement signed by each eligible employee.

M. Employee Incentive Program: At the discretion of the CEO, specific employees may be recognized through incentive compensation, when doing so is consistent with CalOptima Health's business needs and mission, vision, and values.

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N. Retention Incentive: In order to preserve organizational talent and to maintain business continuity when the loss of key personnel may cause risk or damage to operational efficiency, regulatory compliance, and/or strategic imperatives, CalOptima Health may, at the discretion of the CEO, and on an exceptional basis, award a retention incentive.

O. Recruitment Incentive: At the discretion of the CEO, a recruitment incentive of up to fifteen percent (15%) of the midpoint of base pay for the applicable position may be offered to entice an individual to join CalOptima Health. Recruitment incentives of up to a maximum of fifty thousand dollars ($50,000) may be offered for Executive Level Positions and require informing the Board of Directors after approval.

P. Incentive programs may be modified or withdrawn, at any time. An award of incentive compensation is entirely at the discretion of the CEO and/or Board of Directors, as applicable. An award of incentive compensation in one (1) year is not indicative or a guarantee of future awards of incentive compensation and does not alter the at-will nature of employment at CalOptima Health.

Q. Employer-Paid Member Contribution (EPMC): CalOptima Health contributes seven percent (7%) of Compensation Earnable, on behalf of eligible employees who hold Management Staff positions as identified in the CalOptima Health salary schedule, and who qualify based on all of the following:

1. Hired, promoted, or transferred into a Management Staff position, including interim appointments; and

2. Included in one (1) of the following categories:

   a. A CalPERS Classic Member; or

   b. A member prior to January 1, 2013, of another California public retirement system that is eligible for reciprocity with CalPERS.

R. Annual Performance Lump Sum Bonus: Employees paid at or above the pay range maximum are not eligible for future base pay increases. As a result, in lieu of future base pay increases, these employees may be eligible for merit Bonus Pay delivered as a lump sum bonus in accordance with Section III.N. of this Policy, provided that their performance meets the goals and objectives set forth by their managers.

S. Automobile Allowance: CalOptima Health may, at the discretion of the CEO, provide employees in Executive Level Positions, including interim appointments, with a monthly automobile allowance in an amount not to exceed five hundred dollars ($500.00) for the use of their personal vehicle for CalOptima Health business.

T. Supplemental Retirement Benefit: Consistent with applicable Board actions, the CEO is authorized to determine CalOptima Health's contribution rate for employees to a 401(a) tax-qualified supplemental retirement benefit (SRB) plan within the limits of the budget and subject to contribution limits established by applicable laws. With the exception of employees in Executive Level Positions, the contribution rate shall be uniform for all employees. Executive Level Positions will also receive the same uniform contribution rate applicable to all employees. However, for employees in Executive Level Positions who earn more than the applicable compensation limits, the CEO is authorized to provide additional supplemental contributions to the 401(a) SRB plan, subject to the limitations of applicable laws. An employee in an Executive Level Position must still be employed by CalOptima Health at the time the additional supplemental contribution is distributed in order to be eligible to earn and receive the additional supplemental contributions. Government Code

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Sections 7522.72 and 7522.74 require the forfeiture of all accrued rights and benefits in any public retirement system by any public employee convicted of any job-related felony, as of the earliest date of the crime.

U. Work Life Balance Stipend: CalOptima Health shall provide an annual Work Life Balance Stipend of five hundred dollars ($500.00) to Full-Time Employees and two hundred fifty dollars ($250.00) to Part-Time Employees. The stipend is intended to promote employee wellness through enhanced work life balance and may be used for any wellness-related purchases, such as dependent care, gym memberships, yoga classes, art therapy, dietician services, athletic gear, personal development courses, and more. The stipend is taxable and paid in two (2) increments of two hundred fifty dollars ($250.00) to Full-Time Employees and one hundred twenty-five dollars ($125.00) to Part-Time Employees on the pay periods that include November 01, and May 01 each year.

V. Benefit Income: CalOptima Health shall provide a bi-monthly taxable medical stipend as a cost savings measure to CalOptima Health and incentive for employees who have medical coverage outside of CalOptima Health. Employees must submit proof of outside coverage in order to be eligible for this benefit. The amount of the bi-monthly stipend is approved by the Board of Directors on an annual basis.

W. Temporary Upgrade Pay: An employee who is appointed for a limited duration to a job having a higher pay grade is eligible for Temporary Upgrade Pay. The employee must meet the minimum requirements of the position and be performing all essential job functions and responsibilities of the upgraded position without performing duties of their current job to qualify for Temporary Upgrade Pay. Temporary Upgrade Pay will be the minimum of the new pay rate or a five percent (5%) of base pay increase, whichever is greater. Temporary Upgrade Pay will be eliminated when the temporary assignment ends. The temporary assignment shall not exceed nine hundred and sixty (960) hours. Temporary Upgrade Pay is considered premium pay pursuant to Title 2 CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation for CalPERS Classic Members only.

III. PROCEDURE

A. Overtime Pay: Overtime must be approved in advance by an employee's manager. Adjustments for overtime pay cannot be calculated until the completion of an employee's workweek. This may result in one (1) pay period's delay in the employee receiving the additional compensation.

B. Holiday Premium Pay: Working on a CalOptima Health observed holiday must be approved in advance by the employee's manager. Unauthorized work that occurs on an observed holiday is not eligible for Holiday Premium Pay and will be paid at the employee's regular base pay. Actual hours worked on a holiday will be used for purposes of calculating overtime.

C. Bilingual Pay: An employee or potential employee shall undergo a written and verbal language fluency evaluation when bilingual proficiency is a required part of the employee's or potential employee's job and used in the performance of the employee's job duties with members. If the employee or potential employee passes the evaluations, bilingual pay shall be established. For new hires, the Bilingual Pay begins with the first pay period of their employment. Changes to Bilingual Pay will occur at the start of a pay period. Bilingual pay shall not be prorated. Temporary and/or interim assignments will not impact bilingual pay.

D. Translation Pay: If an eligible Exempt Employee elects to provide translation services, and such services are not part of the employee's regular job duties, the employee shall submit their interest to the C&L Department. If selected, the translation pay identified above will be provided depending on

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the variables noted above, taking into account whether professional translation services are either not available or unfeasible due to business constraints.

E. Night Shift:

1. Night Shift differential is automatically calculated for those employees regularly working a night shift, defined as seven (7) hours or more of work between 3:00 p.m. and 8:00 a.m.

2. Employees who, at their own request and for their own convenience, adjust their work schedule, such as requesting make up time or alternative hours, and as a result, would be eligible for night shift pay, shall be deemed as having waived their right to same. When appropriate, a new Action Form should be submitted, removing the employee from the night shift.

F. Call Back and On Call Pay:

1. If employees are on call or get called back to work, the employees are responsible for adding this time to their schedules through CalOptima Health's time keeping system, which is then approved by their supervisors.

G. Commuter Allowance:

1. Commuter Allowance is automatically calculated for eligible employees based on system designation of Full Office Worker or Partial Teleworker. Employees and leaders are responsible for maintaining accurate designations in the timekeeping system. Designation changes require a request and approval per the Telework Program Guidelines. CalOptima Health may periodically audit and validate employee Office/Telework designations.

H. Internet Stipend:

1. Internet Stipend is automatically calculated for eligible employees based on system designation of Full Teleworker, Partial Teleworker, or Community Worker. Employees and leaders are responsible for maintaining accurate designations in the timekeeping system. Telework designation changes require a request and approval per the Telework Program Guidelines. Community Worker designation is determined by the position. CalOptima Health may periodically audit and validate employee Office/Telework designations.

I. Active Certified Case Manager (CCM) Pay:

1. To receive CCM supplemental pay, an employee is responsible for providing a copy of the employee's case management certification issued by the Case Management Society of America to the Human Resources Department. Temporary and/or interim assignments will not impact CCM pay.

J. Executive Incentive Plan

1. The Board of Directors approves CalOptima Health's strategic plan for each fiscal year, and the CEO is expected to meet the goals set forth in the strategic plan. The CEO in turn sets goals for the Executive Level Positions. CalOptima Health's Executive Incentive Pay Plan will be administered in accordance with the CalOptima Health Executive Incentive Plan Guidelines.

K. Employee Sales and Enrollment Incentive Program:

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1. The Executive Director, Medicare Programs or designee will review the Employee Sales and Enrollment Incentive structure for the OneCare and PACE Programs on an annual basis and will submit any required changes to the incentive structure and the OneCare and PACE Employee Sales and Enrollment Incentive Agreements for review and approval by the CEO, or designee.

2. OneCare:

   a. Employees with the job titles of Director I, Sales and Marketing, OneCare Manager Member Outreach and Education; Supervisor Member Outreach and Education; OneCare Community Partner and Community Partner Sr and OneCare Community Partner Inside Sales are eligible for the Sales and Enrollment Incentive Program and will be required to sign a OneCare Sales and Enrollment Incentive Agreement on an annual basis, which may include revisions to the incentive structure or enrollment goals specific each eligible employee job title.

   b. The OneCare Manager Outreach and Education will be responsible for calculating monthly payments for employees who are eligible for the OneCare Sales and Enrollment Incentive Program based on the number of enrollments produced each month according to the terms of the OneCare Sales and Enrollment Incentive Agreement effective at the time the enrollments are produced. The Manager will submit a detailed report of enrollments produced and payments due for approval by the Executive Director, Medicare Programs, and the Chief Financial Officer.

3. PACE:

   a. Employees with the job titles of PACE Supervisor Member Outreach and Education and PACE Enrollment Coordinator are eligible for the Sales and Enrollment Incentive Program and will be required to sign a PACE Sales Incentive Agreement on an annual basis, which may include revisions to the incentive structure or enrollment goals specific to their job title.

   b. The PACE Manager Marketing & Enrollment will be responsible for calculating monthly incentive payments for employees who are eligible for the PACE Sales and Enrollment Incentive Program based on the number of enrollments produced each month according to the terms of the PACE Sales and Enrollment Incentive Program Agreement effective at the time the enrollments are produced. The Manager will submit a detailed report of enrollments produced and payments due for approval by the Executive Director, Medicare Programs, and the Chief Financial Officer.

L. Retention Incentive: As circumstances warrant, the CEO may award an employee a retention incentive to prevent or delay departures that may adversely impact business operations. The employee offered a retention incentive must be in good standing and accept and sign a retention agreement which contains the condition(s) to be met to receive payment. Payment of the incentive will be made when the terms of the agreement have been fully met and at the conclusion of the retention period. The CEO has the authority to offer retention incentives for up to twenty-five (25) employees per fiscal year in an amount not to exceed twenty percent (20%) of the employee's current base annual salary. Retention incentives that exceed twenty percent (20%) of the employee's current base annual salary require Board of Directors' approval.

M. Recruitment Incentive: As circumstances warrant, the CEO may offer a recruitment incentive based on the Compensation Administration Guidelines managed by the Human Resources Department to entice an individual to join CalOptima Health. Recruitment incentives of up to a maximum of fifty thousand dollars ($50,000) may be offered for Executive Level Positions and require informing the

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Board of Directors after approved. To receive the recruitment incentive, the individual offered the incentive is required to accept and sign an offer letter which contains a "claw-back" provision obligating the recipient of a recruitment incentive to return the full amount of the recruitment incentive if the recipient voluntarily terminates employment with CalOptima Health within twenty-four (24) months of the date of hire.

N. Annual Performance Lump Sum Bonus: Once employees have reached the pay range maximum, employees may be eligible for merit Bonus Pay delivered as a lump sum bonus, provided that their annual performance evaluations meet the established goals and objectives set forth by their managers. Merit Bonus Pay will not exceed the maximum percentage of the merit increase matrix and reflects employees' superior performance measured against established objectives. Annual performance lump sum bonuses are paid out in two (2) incremental amounts – the first half when merit salary increases are normally distributed and the second half six (6) months later. The employee must still be employed by CalOptima Health to be eligible to earn and receive the lump sum bonus payments.

O. Automobile Allowance: As circumstances warrant, the CEO may offer employees in Executive Level Positions an automobile allowance in lieu of the IRS standard mileage reimbursement rate that would otherwise apply for the use of their personal vehicle in the performance of their duties. Such automobile allowance will be identified on the employees' W-2 forms as taxable income. In addition, as a condition of receiving such allowance, the employee must comply with the following requirements:

1. Maintain adequate levels of personal vehicle insurance coverage;

2. Purchase their own fuel for the vehicle; and

3. Ensure the vehicle is properly maintained.

P. Work Life Balance Stipend: Work Life Balance Stipend is automatically calculated for eligible employees. To be eligible, employees must be in active status (either working or on a paid LOA) in the pay period that includes May 1 or November 1. Employees on an approved, unpaid LOA when the Work Life Balance Stipend is paid will receive a retroactive payment upon return to active status.

Q. Benefit Income: Once enrolled in Benefit Income, the participating employee's election to waive CalOptima Health medical insurance will remain in effect for the entire, or remaining, plan year (January 1 through December 31) unless the employee has a qualifying event. Benefit Income may be temporarily suspended for employees who are on an approved Leave of Absence (LOA) without pay in accordance with CalOptima Health Policies GA.8039: Pregnancy Disability Leave and Related Workplace Accommodation, GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence, GA.8041: Workers' Compensation Program, or GA.8063: Disability Accommodations. However, retroactive payment for Benefit Income will be applied for the period of protected, unpaid leave upon return to active duty.

R. Temporary Upgrade Pay: Human Resources will calculate Temporary Upgrade Pay for eligible employees who are authorized and appointed for a limited duration to assume the duties of a position with a higher pay grade.

S. Supplemental Compensation During Leave of Absence: An employee on a Continuous LOA is not eligible to receive certain supplemental compensation, such as Bilingual Pay, Night Shift Premium, Call Back or On Call Pay, Active Certified Case Manager (CCM) Pay, Internet Stipend, Commuter Allowance, or Automobile Allowance during their LOA. If applicable, an employee on a

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Continuous LOA may be eligible for Employer-Paid Member Contribution, Supplemental Retirement Benefit and Benefit Income during any portion of a paid LOA but shall not be eligible if the LOA is unpaid. Executive incentives will be prorated to account for an executive's Personal LOA time period. Executives must be current employees during the pay period the executive incentive is paid for eligibility. Supplemental compensation will resume when the employee returns to an active status, and may be prorated, where applicable.

T. Proration: For supplemental compensation that is paid per pay period and not based on hourly pay rate (i.e. Bilingual Pay, Active Certified Case Manager, Internet Stipend, Commuter Allowance, Automobile Allowance, and Benefit Income), such compensation will begin the first Full Pay Period after eligibility is established. These items of compensation will be provided only for Full Pay Periods and will not be prorated for a change in eligibility for a portion of the pay period.

U. Supplemental Compensation for Part-Time Employees

1. If eligible, regular Part-Time Employees will receive pro-rated supplemental compensation based on their approved work schedule, as reflected in the timekeeping system, for the following:

   a. Active Certified Case Manager Pay / Educational Incentive;

   b. Executive Incentive Pay Plan;

   c. Annual Merit Lump Sum Bonus;

   d. Automobile Allowance; and

   e. Benefit Income.

2. Exceptions include the following:

   a. Bilingual Pay, Internet Stipend and Work Life Balance Stipends will be paid in accordance with Section II.

V. Part-Time Employees are not eligible for the Commuter Allowance.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Employee Handbook
B. CalOptima Health Executive Incentive Plan Guidelines
C. CalOptima Health Performance Review of Executives Template
D. CalOptima Health Policy GA.8039: Pregnancy Disability Leave and Related Workplace Accommodation
E. CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence
F. CalOptima Health Policy GA.8041: Workers' Compensation Program
G. CalOptima Health Policy GA.8056: Paid Holidays
H. CalOptima Health Policy GA.8063: Disability Accommodations
I. Compensation Administration Guidelines

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J. Government Code, §20636 and 20636.1
K. PACE Sales and Enrollment Incentive Program Agreement: Supervisor Member Outreach and Education
L. OneCare Sales and Enrollment Incentive Program Agreement: Community Partner and Community Partner Sr
M. OneCare Sales and Enrollment Incentive Program Agreement: Community Partner Inside Sales
N. OneCare Sales and Enrollment Incentive Program Agreement: Supervisor Member Outreach and Education
O. OneCare Sales and Enrollment Incentive Program Agreement: Manager Member Outreach & Education
P. OneCare Sales and Enrollment Incentive Program Agreement: Director I, Sales and Marketing
Q. PACE Sales and Enrollment Incentive Program Agreement: Enrollment Coordinator
R. Telework Program Guidelines
S. Title 2, California Code of Regulations (CCR), §571

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
12/07/2023	Regular Meeting of the CalOptima Health Board of Directors
06/06/2024	Regular Meeting of the CalOptima Health Board of Directors
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8042	Pay Differentials	Administrative
Revised	05/20/2014	GA.8042	Supplemental Compensation	Administrative
Revised	12/03/2015	GA.8042	Supplemental Compensation	Administrative
Revised	09/07/2017	GA.8042	Supplemental Compensation	Administrative
Revised	06/07/2018	GA.8042	Supplemental Compensation	Administrative
Revised	02/07/2019	GA.8042	Supplemental Compensation	Administrative
Revised	04/02/2020	GA.8042	Supplemental Compensation	Administrative
Revised	04/07/2022	GA.8042	Supplemental Compensation	Administrative
Revised	06/02/2022	GA.8042	Supplemental Compensation	Administrative
Revised	05/04/2023	GA.8042	Supplemental Compensation	Administrative
Revised	12/07/2023	GA.8042	Supplemental Compensation	Administrative
Revised	06/06/2024	GA.8042	Supplemental Compensation	Administrative
Revised	06/05/2025	GA.8042	Supplemental Compensation	Administrative

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IX. GLOSSARY

Term	Definition
Bilingual Certified Employee	An employee who has passed CalOptima Health's Bilingual Screening Process either upon hire or any time during their employment.
Bilingual Screening Process	Prospective staff translators are identified by the Cultural and Linguistic (C&L) Services Department based on qualifications obtained through CalOptima Health's bilingual screening process. The screening is either conducted as part of their initial hiring process or later during their employment. All staff translators must possess a strong ability to read, write and understand the target language. Once identified as potential staff translators, they are required to take a proficiency test created by the C&L Services Department. They are evaluated on their vocabulary, grammar, orthography, flow, accuracy, cultural sensitivity, as well as consistency in usage of translated terms. The selection is based on their overall score.
Bonus Pay	Compensation to employees for superior performance such as "annual performance bonus" and "merit pay." If provided only during a member's final compensation period, it shall be excluded from final compensation as "final settlement" pay. A program or system must be in place to plan and identify performance goals and objectives to count as Special Compensation for CalPERS purposes.
CalPERS	California Public Employees Retirement System
CalPERS Classic Member	A member enrolled in CalPERS prior to January 1, 2013.
Community Worker	An employee in a position that performs fifty-one percent (51%) or more of their duties in field locations such as provider offices, members' homes, and at community outreach events.
Compensation Earnable	The pay rate and Special Compensation as defined in Government Code sections 20636 and 20636.1.
Continuous Leave of Absence (LOA)	Leave that is taken uninterruptedly, rather than intermittently.
Executive Level Position	The position of Executive Director or above.
Exempt Employee	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Full Pay Period	A Full Pay Period refers to all of an employee's scheduled work hours within a pay period.
Full Office Worker	An employee who is assigned to work their full schedule at the Central Worksite.
Full Teleworker	An eligible employee who is approved to routinely work their entire regularly scheduled work hours from a Remote Work Location unless business needs require otherwise.
Full-Time Employees	For purposes of this policy, employees who are regularly scheduled to work thirty (30) hours or more per week.
Leave of Absence (LOA)	A term used to describe an authorized period of time off longer than five (5) days that an employee is to be away from their primary job, while maintaining the status of employee.
Management Staff	Staff holding positions at or above Director level.

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Term	Definition
Partial Teleworker	An eligible employee who is approved to work a pre-established consistent weekly work schedule split between two (2) or more full days per week at the Central Worksite, and the remainder of full days at the Remote Work Location.
Part-Time Employees	Employees who are regularly scheduled to work less than thirty (30) hours per week.
Sales Incentive	An amount of money paid, in addition to base pay, to an employee for successfully enrolling a member into the OneCare Program.
Special Compensation	Payment of additional compensation earned separate from an employee's base pay that meets the criteria listed in Title 2, California Code of Regulations (CCR) section 571(a).
Threshold Language	A threshold language as defined by the Centers for Medicare & Medicaid Services (CMS) for Medicare programs, or Department of Health Care Services for the Medi-Cal program.

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CALOPTIMA HEALTH EXECUTIVE INCENTIVE PROGRAM

The Executive Incentive Plan is an annual plan for the members of CalOptima Health's executive team that provides a monetary reward for superior performance based on the achievement of predetermined goals and objectives. The amount of incentive awarded to participants is determined based on goal achievement scores and the availability of budget for incentive payments.

A. Purpose: To align the performance of CalOptima Health's executive staff towards the accomplishment of the agency's long-term strategic plan and to reward outstanding accomplishment of annual key business strategies and initiatives.

B. Eligibility: To be eligible to participate in the Executive Incentive Plan, an employee must be in an executive level position with job titles containing the designation of "Chief" or "Executive."

C. Goals and Objectives: Specific performance goals and objectives are established by the Chief Executive Officer and members of the executive team. Each goal is assigned a weighted percentage, and a description/measure of accomplishment. Goals are established using the following guidelines.

- Linkage to organization strategy
- Stretch objectives with a reasonable probability of attainment
- Consistency in approach across departments
- Encouragement of teamwork among leadership team and the organization, and
- Simple to understand, communicate and administer

D. Performance Period: Accomplishment of goals and objectives will be determined based on performance during the fiscal year (July 1 to June 30).

E. Incentive Opportunity: Goals and objectives are assigned accomplishment points. A minimum score of 50 points is required to be eligible for incentive compensation. The maximum points awarded is 100. The maximum incentive award is ten percent (10%) of the participant's annual base compensation at the time the incentive is calculated. The amount can be prorated based on the number of months of participation in the plan. In order to receive an incentive award, the participant must be an active employee at the time the award is paid out. The range of the potential incentive for Executive Staff is contingent upon a range of performance based upon the goals and objectives established by the Chief Executive Officer. Based upon the total accomplishment points received, the incentive opportunities may be determined based upon a performance matrix, as an example, as follows:

Points	Category	Description	Incentive as Percentage of Base Pay
Below 50	Below Threshold	The minimum level of performance was not achieved	0%

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Points	Category	Description	Incentive as Percentage of Base Pay
50-60	Threshold	The minimum level of performance which must be achieved before an incentive is paid	0-4%
60-70	Target	The level of performance which generally equates to the achievement of some but not all goals and objectives	4-6%
70-85	Commendable	The level of performance where the combination of personal effort and business produce an above average return for the organization	6-8%
85-100	Outstanding	The very superior level of performance which occasionally occurs when all circumstances come together to produce very high returns for the organization.	8-10%

F. Modification of Plan: The CEO may modify the plan for business need at any time. Participation in the plan is subject to the approval of the CEO. Participation in any single year does not predict participation in subsequent years.

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Sample Form

Executive Incentive Goals for FY___- ___

Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment / Points Available	Points Earned	Owner(s)	Comment/Notes
Quality Programs and Services	*Goal XYZ*	*10*	*Implement by Q1. Program rolled out to all users. 0 – 25, 0 if not met, 25 if fully met.*	*15*	*Chief Operating Officer*	*Partial completion.*
Culture, Learning and Innovation						
Financial Stability						
Strong Internal Processes						
Community Outreach						

Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment / Points Available	Points Earned	Owner(s)	Comment/Notes
			Total Score			

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Performance Review – Executive (Directors and Above)

EMPLOYEE INFORMATION

EMPLOYEE	JOB TITLE	DEPARTMENT

SUPERVISOR/EVALUATOR	REVIEW PERIOD
	to

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SELF REVIEW: In the following section, provide your responses to the following questions for the review period April 1, YYYY, through March 31, YYYY.

1) **What did you do well that impacted or demonstrated your performance? (Examples: accomplishments, self-development, projects, productivity, collaboration, customer service)**
2) **What are you continuing to work on that you set as goal(s) from last year?**
3) **What opportunities for growth, future goals or enhancement to your position will sustain and/or improve your performance?**

1)

2)

3)

Manager Review: ***Below are the Core Competencies to be completed by your manager***

CORE BEHAVIORAL COMPETENCIES

This section describes the core competencies required for successful employee performance for this CalOptima Health position. In the space provided, mark the appropriate rating with an "x" and provide comments as needed. Evaluate the employee on each factor relevant to the job duties and responsibilities by indicating to what degree the employee demonstrates the overall skill or behavior on the job.

Competency Rating Scale Definitions:

Outstanding – Performance **regularly exceeds** job expectations due to **exceptionally high quality** of work in all essential areas of responsibility, resulting in outstanding contribution. Reserved for truly outstanding performance.

Exceeds Expectations - Often demonstrates behaviors that go **above and beyond** expectations in order to achieve exceptional performance or intended results.

Fully Meets Expectations - Demonstrates effective and desired behaviors that **consistently** meet **expected** performance standards.

Needs Development - Demonstrates **some** desired behaviors or uses behaviors **inconsistently**. Requires some development/improvement.

Unacceptable - Rarely demonstrates competency behaviors. **Does not meet** performance standards. Requires **significant** and **immediate** improvement

COMMUNICATION: • Communicates well with others in both verbal and written form by adapting tone, style and approach based on people's perspectives and situations. Organizes thoughts, expresses them clearly and respectfully. • Listens attentively to ideas of others; cooperates and builds good working relationships with others. • Provides colleagues with regular and reliable information, including updates on own activities/decisions, and is well-prepared when speaking in front of a group; presentations are clear and informative.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
List specific examples or details of past performance and self-development	
CUSTOMER FOCUS (internal and/or external) • Actively listens and follows up/through on customer inquiries/requests in a timely, professional, courteous, and sensitive manner; ensures clear and frequent communication with customers about progress, changes and status; takes responsibility for correcting customer problems. • Demonstrates a good understanding of company/department procedures for handling customer complaints; knows when to bring in help/use the chain of command for problems beyond ability. • Demonstrates collaborative relationships with others. • Viewed as a team player. Assists others in achieving their goals.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
List specific examples or details of past performance and self-development	
LEADERSHIP: • Communicates high level priorities and objectives, a compelling and strategic vision, which is innovative and future-oriented, and creates buy-in at various levels of the organization for each fiscal year. • Manages, inspires, motivates, develops, reviews, and supports the growth of the organization and department staff.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
List specific examples or details of past performance and self-development	
STRATEGIC THINKING: • Applies the SWOT analysis to CalOptima Health's changing environment to identify opportunities for success in order to redirect the company's course, create realistic and well-balanced strategic plans, and to meet new targets. Understands the players in our industry, both competitors and allies, and is on top of industry shifts and changes. • Includes key stakeholders in strategic planning.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
List specific examples or details of past performance and self-development	

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DECISION MAKING/PROBLEM SOLVING: • Uses sound and consistent judgment when analyzing situations and making decisions that would impact both the department and the entire organization; able to identify potential problems and offers multiple solutions; is conscientious of the department resources. • Able to make decisions even when conditions are uncertain, or information is not available by using the correct balance of logic and intuition; discusses decision and its impact with those who will be affected; the group benefits from input in problem solving and brainstorming sessions. • Reliable, persistent worker who keeps a positive outlook and does not let unexpected problems stop him/her from successfully completing own work; calm under pressure.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable

List specific examples or details of past performance and self-development

PREVIOUS MANAGER'S COMMENTS (if applicable):

List goals that will sustain and/or improve performance, and how they will be measured/evaluated during the next review period:

FINAL OVERALL RATING	Outstanding Exceeds Expectations Fully Meets Expectations Needs Development Unacceptable

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Manager's/Evaluator's Comments

Manager's/Evaluator's Signature:

Signature Date

Second Level Manager's Comments and Signature:

Signature _____ Date _____

Employee's Acknowledgement and Comments:

Signature _____ Date _____

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Policy:	GA.8047
Title:	**Reduction in Force**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	02/01/2014
Revised Date:	06/05/2025
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy defines how CalOptima Health shall administer a Reduction in Force (RIF) program. A RIF occurs when changing priorities, budgetary constraints, or other business conditions require CalOptima Health to eliminate positions.

II. POLICY

A. All CalOptima Health employees are At-Will employees. An employee is terminated as part of the RIF program through no fault of their own. The RIF is considered an involuntary separation of employment that is intended to be permanent as a result of:

1. Lack of work, changing priorities, budgetary constraints, or other business reasons; or

2. A determination by management that, due to business reasons, an employee's performance, or contribution to the business (although satisfactory), does not meet the needs of the business.

B. As part of the RIF program, CalOptima Health shall evaluate the business needs of the organization and the need for particular positions. CalOptima Health shall take into account the relative value of work performed by specific employees, including, but not limited to, performance, qualifications, ~~discipline~~corrective action, attendance, and length of service, so that CalOptima Health can continue to provide the highest level of service possible with a reduced work force. In implementing a RIF program, CalOptima Health may consider, depending on the circumstances, various factors, including, but not limited to, the following (which are not presented in any order of importance):

1. CalOptima Health's need, or lack thereof, for the position occupied by the employee;

2. The contributions which the employee has made to the success of the organization, and the perceived likelihood of contributions to the success of the business in the foreseeable future;

3. Demonstrated high quality performance on the same, or related, assignments;

4. Versatility and ability in applying pertinent skills and experience to current and expected business requirements;

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5. The employee's length of service in the particular position to be retained;

6. The employee's length of service with CalOptima Health;

7. CalOptima Health's need to maintain continuity with respect to a particular project or team; and

8. The more recent performance of the employee compared to others in the same classification.

C. In cases where management determines the various factors considered are essentially equal between two (2) or more employees, length of service in the position and/or length of service at CalOptima Health may be the deciding factor in determining which employee, or employees, shall be retained. In the event an employee who is being laid off has greater length of service in the position and/or length of service at CalOptima Health than an employee, or employees, being retained within the same classification and specialty in the impacted department, CalOptima Health must document the basis, in the judgment of management, the employee with less length of service is better suited for retention.

D. The Human Resources Department shall consult with legal counsel to implement the RIF program to ensure compliance with all applicable federal, state, and local laws and regulations.

E. An employee terminated as part of the RIF program must continue to perform their duties satisfactorily until the Separation Date. Otherwise, the employee may be subject to ~~disciplinary~~ corrective action, up to and including termination, prior to the specified Separation Date, consistent with CalOptima Health Policy GA.8022: Performance and Behavior Standards. An employee terminated as a result of failure to perform duties satisfactorily until the Separation Date shall not be qualified to receive any benefits administered as part of the RIF program.

F. Limitations to Eligibility

1. An employee terminated as part of the RIF program will not be eligible to receive benefits under the plan if the employee:

   a. Is terminated for cause, including but not limited to, failure to meet the performance requirements of the position, policy violation, theft, gross misconduct, etc.;~~ or~~

   b. Fails, or refuses, to return all CalOptima Health property in the employee's possession, and/or fails to clear all expense and other financial accounts, as of the date of termination. (Examples of CalOptima Health property include, but are not limited to: CalOptima Health Security badges, office keys any and all CalOptima Health documents, files, and computers. Examples of accounts to be cleared include, but are not limited to, the completion and reconciliation of expense accounts); ~~or~~

   c. Resigns, or otherwise voluntarily terminates, their employment; ~~or~~

   d. Is terminated by temporary layoff, or furlough, except that if CalOptima Health elects to convert the temporary layoff, or furlough, into a permanent layoff, severance pay may then be payable as of the effective date of permanent layoff, if the employee otherwise is eligible for benefits under the RIF program; ~~or,~~

   e. Is on a leave of absence, except that if an employee is released to return to work from an approved leave of absence and CalOptima Health has no assignment for the employee, they may be eligible for benefits under the RIF program; ~~or~~

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f. Is offered a comparable position within CalOptima Health in lieu of termination, but fails, or refuses, to accept it; ~~or~~

g. Is terminated because of CalOptima Health's sale, or transfer, of all, or part, of its assets and their employment continues with the agency, or transferee organization, after the transfer has been completed; ~~or~~

h. Is terminated in connection with the "outsourcing" of operational functions, and they are offered comparable employment by the outsourcing vendor. For this purpose, comparable employment shall be defined as a position with substantially the same duties, at the same, or greater, compensation and comparable benefits, which does not require relocation, as defined by the IRS; ~~or~~

i. Is terminated from employment for failure to return to work following a leave of absence; ~~or~~

j. Retires; ~~or~~

k. Is deceased, at which time eligibility for benefits under the RIF program will end and all such benefit payments, if any, will cease; ~~or~~

l. Is separated from CalOptima Health because they are no longer able to perform the essential functions of their job with or without reasonable accommodation because of a disability; ~~or~~

m. Is a temporary employee, intern/volunteer, independent contractor or consultant; ~~or~~

n. Is an employee employed by CalOptima Health pursuant to a written contract containing provisions for severance benefits; or

o. Is convicted of a crime involving an abuse of their office, or position.

G. This policy sets forth general guidelines to observe in the event of a RIF; however, this policy may be subject to change, deviation, or modification, without notice, depending on the circumstances. Any decision to deviate from this policy in any particular case shall be subject to the discretion of the Chief Executive Officer (CEO).

H. Applicable provisions of this policy may also be used to address employee separations or terminations, other than a RIF, where appropriate, at the discretion of the CEO.

III. PROCEDURE

A. Affected Positions: Following an evaluation of CalOptima Health's business needs, CalOptima Health, through appropriate Executive Officers and the Human Resources (HR) Department (hereinafter referred to as the "management"), will identify and determine the positions that will be eliminated and/or affected by a RIF. Management also has the discretion to determine the manner in which the RIF will occur; however, notification to the HR Department should precede the implementation of the RIF.

B. Determinations: Determinations concerning the evaluation of employees, the considerations evaluated, and final recommendations should be made by the employee's immediate supervisor and/or manager with the next higher management level. Documentation of all considerations

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evaluated should be furnished to HR and approved by management prior to any notification to the employee affected by the RIF.

C. Transfers or Downgrades: Depending on CalOptima Health's business needs, an employee impacted by the RIF may be offered a downgrade (a lower position and/or reduction in base pay) or lateral transfer (an equivalent position and/or equivalent base pay) to another open ~~job~~ position for which they are, in the judgment of management, most qualified even though it is a ~~job~~ position or classification that the employee has not previously held in lieu of layoff. An employee impacted by the RIF who is offered a lateral transfer, or downgrade, may be provided the option of layoff. HR shall determine, on a case-by-case basis, the time period appropriate to accept, or decline, such job offer. An employee who downgrades positions under this policy may be assigned to the pay rate nearest to their present pay rate within the pay grade of the position in which they are demoting provided that it does not exceed the pay range maximum of the new position.

D. Employee Notices: Employees who are to be laid off as a result of the RIF should be notified of such reduction only after all necessary approvals have been obtained. The notice will contain the general reason for the layoff and Separation Date. An employee notified of a lay-off must continue to work up to the Separation Date specified in the notice unless management decides otherwise. An employee notified of their lay-off, as a result of the RIF, may not subsequently be placed on a leave of absence (LOA) without prior approval of the ~~Executive Director of HR.~~Chief Human Resources Officer.

E. Severance: Severance pay may be offered, if approved by the CEO and HR, upon an employee's separation from service when it is deemed appropriate due to special circumstances. If severance pay is authorized and offered, it will be paid in accordance with the following, unless otherwise defined in a separate employee agreement, or approved by the CEO:

1. Two (2) weeks of pay at the rate of the Annual Earnings for employees with less than two (2) years of service and more than ninety (90) days; or

2. One (1) week of pay at the rate of the Annual Earnings for each completed year of service, with a maximum of sixteen (16) weeks, for employees with two (2) years or more of service.

F. Employees on a Leave of Absence: If an employee is on a Leave of Absence (LOA), and their position is terminated as part of the RIF, CalOptima Health will not terminate the LOA early to implement the RIF program. The employee will be laid off at the scheduled, or required, conclusion of the LOA. This paragraph does not apply to employees on Personal LOA, pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence.

G. Release Agreement: In order to be eligible for the severance pay, if offered, an eligible employee must fully complete and execute a separation agreement provided by CalOptima Health, in a form approved by legal counsel, at, or near the time of, termination. This separation agreement includes a release of all known and unknown claims the employee has, or may have, against CalOptima Health, as well as an agreement of confidentiality, non-disparagement, and non-solicitation. To be eligible for the severance pay, the separation agreement must be signed by the employee and must become irrevocable, in accordance with applicable law.

H. Payment Method: All wages earned and unpaid, including paid time off (PTO) and flex holidays, on the specified Separation Date will be paid to the employee in accordance with CalOptima Health's pay schedule and not necessarily on the employee's Separation Date. CalOptima Health may make payment of severance pay, if an employee is eligible, in accordance with the CalOptima Health payroll schedule as if the recipient were still employed or in a lump sum payment, following a seven

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(7) day waiting period, where applicable, and after receipt of the fully executed and irrevocable separation agreement and/or any other agreement. Payment in installments will be equal to the employee's bi-weekly Annual Earnings wages, less applicable taxes and deductions, including benefits, if applicable, until the agreed upon sum has been distributed. Eligible employees receiving payment in installments shall be required to remain reasonably available during the time period the employee is receiving periodic severance payments to respond to questions from CalOptima Health and address work related matters. Payment by lump sum will be distributed on CalOptima Health's next regularly scheduled payday and will be equal to the amount the employee would have made in wages for the applicable number of weeks of severance pay offered, less applicable taxes and deductions.

I. Taxes: CalOptima Health shall reduce all severance pay by all applicable federal, state, or local tax withholdings.

J. Termination of Severance Pay: If a former employee is receiving severance pay through periodic payments as described in Section III.H., severance pay will immediately cease if CalOptima Health discovers that the employee:

1. Has failed to return all CalOptima Health property; ~~or~~
2. Has disclosed or used confidential information about CalOptima Health for the benefit of a third party; ~~or~~
3. Has defamed CalOptima Health; ~~or~~
4. Has been hired on a full-time basis by another employer; ~~or~~
5. Has failed to remain reasonably available to respond to CalOptima Health questions, or work-related matters~~.~~;
6. Has attempted to entice other employees of CalOptima Health to work for a competitor; or
7. Has been convicted of a crime involving an abuse of their office, or position.

K. Death: If a former employee dies before all payments have been made, severance payments will cease. No benefits will continue to a beneficiary.

L. Returning to Work: If an employee is eligible for and receives benefits under this policy, and that employee later returns to work for CalOptima Health before receiving all payments under this policy, further severance payments will cease effective on the rehire date. If the employee later becomes eligible for benefits under this policy, the subsequent severance payment calculated based on the total years of service will be reduced by the amount of severance payments previously paid.

M. Retirement Benefits: The receipt of severance pay under this policy shall have no effect on the employee's right, if any, to retiree benefits under any other employee pension, or welfare benefit plan.

N. Other Benefits: Other than severance pay, employees shall not be offered, or provided, any other benefits (health, dental, vision, life insurance, or CalPERS/PARS payments). If the employee is being paid by lump sum as described in Section III.H., medical, dental, and vision benefits shall cease on the last day of the month in the same month as the Separation Date, unless otherwise determined by the CEO. All other benefits, including, but not limited to, life insurance and payment

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towards CalPERS and PARS ends on the Separation Date. If the employee is receiving severance pay through periodic payments as described in Section III.H. above, medical, dental, vision, and other applicable benefits, as determined solely by HR, may cease on the last day of the month in the same month the employee receives their last periodic severance payment, unless otherwise determined by the CEO.

O. Time Limits: All time limits herein refer to calendar days. If the expiration of any time limits of this policy falls on a weekend, or a holiday observed by CalOptima Health, the time limit will be deemed to end on the next workday.

P. Source of Benefits: The benefits provided under this policy shall be unfunded and payable solely from the CalOptima Health's general fund.

Q. No Individual Liability: It is the express purpose and intention of CalOptima Health that no individual liability whatsoever shall attach to, or be incurred by, any director, officer, Board Member, executive, employee, representative, or agent of CalOptima Health. This Policy does not guarantee a right to any employee for severance pay, and such benefit shall be offered at the sole discretion of CalOptima Health.

R. No Employment References: If an employee terminated as part of the RIF program requests an employment reference from CalOptima Health, CalOptima Health shall only provide the employee's date(s) of employment and position in response to such requests. All reference requests must be directed to HR.

S. No Vested Right: This policy does not guarantee a right to any employee for severance pay, and such benefit, if offered, shall be at the sole discretion of CalOptima Health.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Age Discrimination in Employment Act, 29 U.S.C. §621 *et seq.*
B. California Government Code §12964.5
C. California Labor Code §1400 *et seq.*
D. CalOptima Health Employee Handbook
E. CalOptima Health Policy GA.8022: Performance and Behavior Standards
F. CalOptima Health Policy GA.8038: Personal Leave of Absence
G. California Older Workers Benefit Protection Act, 29 U.S.C. §§623, 626 & 630
H. Worker Adjustment and Retraining Notification Act (WARN), 29 U.S.C. §2101 *et seq*.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors

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Date	Meeting
04/05/2018	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2014	GA.8047	Reduction In Force	Administrative
Revised	08/07/2014	GA.8047	Reduction In Force	Administrative
Revised	12/01/2016	GA.8047	Reduction In Force	Administrative
Revised	04/05/2018	GA.8047	Reduction In Force	Administrative
Revised	12/03/2020	GA.8047	Reduction In Force	Administrative
Revised	12/01/2022	GA.8047	Reduction In Force	Administrative
Revised	06/05/2025	GA.8047	Reduction In Force	Administrative

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IX. GLOSSARY

Term	Definition
Annual Earnings	The annualized base salary of the employee as of the Separation Date, without regard to overtime, car allowances, bonus, incentive payments or commission payments.
At-Will	An employment, having no specified term, may be terminated at the will of employees or the employer at any time and with or without cause.
Service	All periods of employment with CalOptima Health, provided that service does not include periods in which an employee is on a Personal leave of absence pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence, and service shall not include any period of employment for which the employee has received severance pay under the RIF program or under any similar plan of CalOptima Health's.
Separation Date	The last day of employment with CalOptima Health.

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Policy:	GA.8047
Title:	**Reduction in Force**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	02/01/2014
Revised Date:	06/05/2025
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy defines how CalOptima Health shall administer a Reduction in Force (RIF) program. A RIF occurs when changing priorities, budgetary constraints, or other business conditions require CalOptima Health to eliminate positions.

II. POLICY

A. All CalOptima Health employees are At-Will employees. An employee is terminated as part of the RIF program through no fault of their own. The RIF is considered an involuntary separation of employment that is intended to be permanent as a result of:

1. Lack of work, changing priorities, budgetary constraints, or other business reasons; or

2. A determination by management that, due to business reasons, an employee's performance, or contribution to the business (although satisfactory), does not meet the needs of the business.

B. As part of the RIF program, CalOptima Health shall evaluate the business needs of the organization and the need for particular positions. CalOptima Health shall take into account the relative value of work performed by specific employees, including, but not limited to, performance, qualifications, corrective action, attendance, and length of service, so that CalOptima Health can continue to provide the highest level of service possible with a reduced work force. In implementing a RIF program, CalOptima Health may consider, depending on the circumstances, various factors, including, but not limited to, the following (which are not presented in any order of importance):

1. CalOptima Health's need, or lack thereof, for the position occupied by the employee;

2. The contributions which the employee has made to the success of the organization, and the perceived likelihood of contributions to the success of the business in the foreseeable future;

3. Demonstrated high quality performance on the same, or related, assignments;

4. Versatility and ability in applying pertinent skills and experience to current and expected business requirements;

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5. The employee's length of service in the particular position to be retained;

6. The employee's length of service with CalOptima Health;

7. CalOptima Health's need to maintain continuity with respect to a particular project or team; and

8. The more recent performance of the employee compared to others in the same classification.

C. In cases where management determines the various factors considered are essentially equal between two (2) or more employees, length of service in the position and/or length of service at CalOptima Health may be the deciding factor in determining which employee, or employees, shall be retained. In the event an employee who is being laid off has greater length of service in the position and/or length of service at CalOptima Health than an employee, or employees, being retained within the same classification and specialty in the impacted department, CalOptima Health must document the basis, in the judgment of management, the employee with less length of service is better suited for retention.

D. The Human Resources Department shall consult with legal counsel to implement the RIF program to ensure compliance with all applicable federal, state, and local laws and regulations.

E. An employee terminated as part of the RIF program must continue to perform their duties satisfactorily until the Separation Date. Otherwise, the employee may be subject to corrective action, up to and including termination, prior to the specified Separation Date, consistent with CalOptima Health Policy GA.8022: Performance and Behavior Standards. An employee terminated as a result of failure to perform duties satisfactorily until the Separation Date shall not be qualified to receive any benefits administered as part of the RIF program.

F. Limitations to Eligibility

1. An employee terminated as part of the RIF program will not be eligible to receive benefits under the plan if the employee:

a. Is terminated for cause, including but not limited to, failure to meet the performance requirements of the position, policy violation, theft, gross misconduct, etc.;

b. Fails, or refuses, to return all CalOptima Health property in the employee's possession, and/or fails to clear all expense and other financial accounts, as of the date of termination. (Examples of CalOptima Health property include, but are not limited to: CalOptima Health Security badges, office keys any and all CalOptima Health documents, files, and computers. Examples of accounts to be cleared include, but are not limited to, the completion and reconciliation of expense accounts);

c. Resigns, or otherwise voluntarily terminates, their employment;

d. Is terminated by temporary layoff, or furlough, except that if CalOptima Health elects to convert the temporary layoff, or furlough, into a permanent layoff, severance pay may then be payable as of the effective date of permanent layoff, if the employee otherwise is eligible for benefits under the RIF program;

e. Is on a leave of absence, except that if an employee is released to return to work from an approved leave of absence and CalOptima Health has no assignment for the employee, they may be eligible for benefits under the RIF program;

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f. Is offered a comparable position within CalOptima Health in lieu of termination, but fails, or refuses, to accept it;

g. Is terminated because of CalOptima Health's sale, or transfer, of all, or part, of its assets and their employment continues with the agency, or transferee organization, after the transfer has been completed;

h. Is terminated in connection with the "outsourcing" of operational functions, and they are offered comparable employment by the outsourcing vendor. For this purpose, comparable employment shall be defined as a position with substantially the same duties, at the same, or greater, compensation and comparable benefits, which does not require relocation, as defined by the IRS;

i. Is terminated from employment for failure to return to work following a leave of absence;

j. Retires;

k. Is deceased, at which time eligibility for benefits under the RIF program will end and all such benefit payments, if any, will cease;

l. Is separated from CalOptima Health because they are no longer able to perform the essential functions of their job with or without reasonable accommodation because of a disability;

m. Is a temporary employee, intern/volunteer, independent contractor or consultant;

n. Is an employee employed by CalOptima Health pursuant to a written contract containing provisions for severance benefits; or

o. Is convicted of a crime involving an abuse of their office, or position.

G. This policy sets forth general guidelines to observe in the event of a RIF; however, this policy may be subject to change, deviation, or modification, without notice, depending on the circumstances. Any decision to deviate from this policy in any particular case shall be subject to the discretion of the Chief Executive Officer (CEO).

H. Applicable provisions of this policy may also be used to address employee separations or terminations, other than a RIF, where appropriate, at the discretion of the CEO.

III. PROCEDURE

A. Affected Positions: Following an evaluation of CalOptima Health's business needs, CalOptima Health, through appropriate Executive Officers and the Human Resources (HR) Department (hereinafter referred to as the "management"), will identify and determine the positions that will be eliminated and/or affected by a RIF. Management also has the discretion to determine the manner in which the RIF will occur; however, notification to the HR Department should precede the implementation of the RIF.

B. Determinations: Determinations concerning the evaluation of employees, the considerations evaluated, and final recommendations should be made by the employee's immediate supervisor and/or manager with the next higher management level. Documentation of all considerations

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evaluated should be furnished to HR and approved by management prior to any notification to the employee affected by the RIF.

C. Transfers or Downgrades: Depending on CalOptima Health's business needs, an employee impacted by the RIF may be offered a downgrade (a lower position and/or reduction in base pay) or lateral transfer (an equivalent position and/or equivalent base pay) to another open position for which they are, in the judgment of management, most qualified even though it is a position or classification that the employee has not previously held in lieu of layoff. An employee impacted by the RIF who is offered a lateral transfer, or downgrade, may be provided the option of layoff. HR shall determine, on a case-by-case basis, the time period appropriate to accept, or decline, such job offer. An employee who downgrades positions under this policy may be assigned to the pay rate nearest to their present pay rate within the pay grade of the position in which they are demoting provided that it does not exceed the pay range maximum of the new position.

D. Employee Notices: Employees who are to be laid off as a result of the RIF should be notified of such reduction only after all necessary approvals have been obtained. The notice will contain the general reason for the layoff and Separation Date. An employee notified of a layoff must continue to work up to the Separation Date specified in the notice unless management decides otherwise. An employee notified of their layoff, as a result of the RIF, may not subsequently be placed on a leave of absence (LOA) without prior approval of the Chief Human Resources Officer.

E. Severance: Severance pay may be offered, if approved by the CEO and HR, upon an employee's separation from service when it is deemed appropriate due to special circumstances. If severance pay is authorized and offered, it will be paid in accordance with the following, unless otherwise defined in a separate employee agreement, or approved by the CEO:

1. Two (2) weeks of pay at the rate of the Annual Earnings for employees with less than two (2) years of service and more than ninety (90) days; or

2. One (1) week of pay at the rate of the Annual Earnings for each completed year of service, with a maximum of sixteen (16) weeks, for employees with two (2) years or more of service.

F. Employees on a Leave of Absence: If an employee is on a Leave of Absence (LOA), and their position is terminated as part of the RIF, CalOptima Health will not terminate the LOA early to implement the RIF program. The employee will be laid off at the scheduled, or required, conclusion of the LOA. This paragraph does not apply to employees on Personal LOA, pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence.

G. Release Agreement: In order to be eligible for the severance pay, if offered, an eligible employee must fully complete and execute a separation agreement provided by CalOptima Health, in a form approved by legal counsel, at, or near the time of, termination. This separation agreement includes a release of all known and unknown claims the employee has, or may have, against CalOptima Health, as well as an agreement of confidentiality, non-disparagement, and non-solicitation. To be eligible for the severance pay, the separation agreement must be signed by the employee and must become irrevocable, in accordance with applicable law.

H. Payment Method: All wages earned and unpaid, including paid time off (PTO) and flex holidays, on the specified Separation Date will be paid to the employee in accordance with CalOptima Health's pay schedule and not necessarily on the employee's Separation Date. CalOptima Health may make payment of severance pay, if an employee is eligible, in accordance with the CalOptima Health payroll schedule as if the recipient were still employed or in a lump sum payment, following a seven (7) day waiting period, where applicable, and after receipt of the fully executed and irrevocable

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separation agreement and/or any other agreement. Payment in installments will be equal to the employee's bi-weekly Annual Earnings wages, less applicable taxes and deductions, including benefits, if applicable, until the agreed upon sum has been distributed. Eligible employees receiving payment in installments shall be required to remain reasonably available during the time period the employee is receiving periodic severance payments to respond to questions from CalOptima Health and address work related matters. Payment by lump sum will be distributed on CalOptima Health's next regularly scheduled payday and will be equal to the amount the employee would have made in wages for the applicable number of weeks of severance pay offered, less applicable taxes and deductions.

I. Taxes: CalOptima Health shall reduce all severance pay by all applicable federal, state, or local tax withholdings.

J. Termination of Severance Pay: If a former employee is receiving severance pay through periodic payments as described in Section III.H., severance pay will immediately cease if CalOptima Health discovers that the employee:

1. Has failed to return all CalOptima Health property;

2. Has disclosed or used confidential information about CalOptima Health for the benefit of a third party;

3. Has defamed CalOptima Health;

4. Has been hired on a full-time basis by another employer;

5. Has failed to remain reasonably available to respond to CalOptima Health questions, or work-related matters;

6. Has attempted to entice other employees of CalOptima Health to work for a competitor; or

7. Has been convicted of a crime involving an abuse of their office, or position.

K. Death: If a former employee dies before all payments have been made, severance payments will cease. No benefits will continue to a beneficiary.

L. Returning to Work: If an employee is eligible for and receives benefits under this policy, and that employee later returns to work for CalOptima Health before receiving all payments under this policy, further severance payments will cease effective on the rehire date. If the employee later becomes eligible for benefits under this policy, the subsequent severance payment calculated based on the total years of service will be reduced by the amount of severance payments previously paid.

M. Retirement Benefits: The receipt of severance pay under this policy shall have no effect on the employee's right, if any, to retiree benefits under any other employee pension, or welfare benefit plan.

N. Other Benefits: Other than severance pay, employees shall not be offered, or provided, any other benefits (health, dental, vision, life insurance, or CalPERS/PARS payments). If the employee is being paid by lump sum as described in Section III.H., medical, dental, and vision benefits shall cease on the last day of the month in the same month as the Separation Date, unless otherwise determined by the CEO. All other benefits, including, but not limited to, life insurance and payment towards CalPERS and PARS ends on the Separation Date. If the employee is receiving severance

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pay through periodic payments as described in Section III.H. above, medical, dental, vision, and other applicable benefits, as determined solely by HR, may cease on the last day of the month in the same month the employee receives their last periodic severance payment, unless otherwise determined by the CEO.

O. Time Limits: All time limits herein refer to calendar days. If the expiration of any time limits of this policy falls on a weekend, or a holiday observed by CalOptima Health, the time limit will be deemed to end on the next workday.

P. Source of Benefits: The benefits provided under this policy shall be unfunded and payable solely from the CalOptima Health's general fund.

Q. No Individual Liability: It is the express purpose and intention of CalOptima Health that no individual liability whatsoever shall attach to, or be incurred by, any director, officer, Board Member, executive, employee, representative, or agent of CalOptima Health. This Policy does not guarantee a right to any employee for severance pay, and such benefit shall be offered at the sole discretion of CalOptima Health.

R. No Employment References: If an employee terminated as part of the RIF program requests an employment reference from CalOptima Health, CalOptima Health shall only provide the employee's date(s) of employment and position in response to such requests. All reference requests must be directed to HR.

S. No Vested Right: This policy does not guarantee a right to any employee for severance pay, and such benefit, if offered, shall be at the sole discretion of CalOptima Health.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Age Discrimination in Employment Act, 29 U.S.C. §621 *et seq.*
B. California Government Code §12964.5
C. California Labor Code §1400 *et seq.*
D. CalOptima Health Employee Handbook
E. CalOptima Health Policy GA.8022: Performance and Behavior Standards
F. CalOptima Health Policy GA.8038: Personal Leave of Absence
G. California Older Workers Benefit Protection Act, 29 U.S.C. §§623, 626 & 630
H. Worker Adjustment and Retraining Notification Act (WARN), 29 U.S.C. §2101 *et seq.*

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
04/05/2018	Regular Meeting of the CalOptima Board of Directors

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Date	Meeting
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2014	GA.8047	Reduction In Force	Administrative
Revised	08/07/2014	GA.8047	Reduction In Force	Administrative
Revised	12/01/2016	GA.8047	Reduction In Force	Administrative
Revised	04/05/2018	GA.8047	Reduction In Force	Administrative
Revised	12/03/2020	GA.8047	Reduction In Force	Administrative
Revised	12/01/2022	GA.8047	Reduction In Force	Administrative
Revised	06/05/2025	GA.8047	Reduction In Force	Administrative

For 20250605 BOD Rev

IX. GLOSSARY

Term	Definition
Annual Earnings	The annualized base salary of the employee as of the Separation Date, without regard to overtime, car allowances, bonus, incentive payments or commission payments.
At-Will	An employment, having no specified term, may be terminated at the will of employees or the employer at any time and with or without cause.
Service	All periods of employment with CalOptima Health, provided that service does not include periods in which an employee is on a Personal leave of absence pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence, and service shall not include any period of employment for which the employee has received severance pay under the RIF program or under any similar plan of CalOptima Health's.
Separation Date	The last day of employment with CalOptima Health.

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Policy:	GA.8062
Title:	**Social Media Conduct**
Department:	Human Resources~~CalOptima Health Administrative~~
Section:	Not Applicable~~Human Resources~~
CEO Approval:	*/s/*
Effective Date:	12/01/2022
Revised Date:	06/05/2025
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE ~~☒ Administrative~~

For 20250605 BOD Review Only

I. PURPOSE

This policy outlines requirements for CalOptima Health Employee communication in Online Communities and compliance with legal and regulatory requirements, including laws concerning privacy and confidentiality.

II. POLICY

A. The emergence of digital communication technologies has led to various activities that integrate technology, social interaction, and the construction of words, pictures, videos, and audio, commonly referred to as Social Media.

B. CalOptima Health recognizes that Online Communities can promote better communication with CalOptima Health Members, business partners, the public, traditional and non-traditional media, and other community stakeholders.

C. CalOptima Health's Communications department controls the content on official sites and approves the links on the CalOptima Health website.

D. The California Public Records Act, the Federal Electronic Communications Privacy Act, Federal Communications Commission guidelines, court-directed action, or other legal requirements may obligate CalOptima Health to disclose information produced by CalOptima Health Employees electronically. If so, CalOptima Health shall not, in any way, be liable for the disclosure.

E. The personal opinions of CalOptima Health Employees who use Social Media or communicate through Online Communities do not represent CalOptima Health.

~~1. Online Communities include, but are not limited to, postings in online forums, blogs, micro-blogs, wikis or vlogs, such as Facebook, Instagram, Twitter, LinkedIn, MySpace, YouTube, Flickr, RSS feeds, media sites, or similar types of online forums.~~

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III. PROCEDURE

A. CalOptima Health-Hosted Social Media Sites

1. CalOptima Health's Communications department shall maintain CalOptima Health's official presence in Online Communities in accordance with policies and operational procedures. Communications in Online Communities shall be consistent with CalOptima Health values and applicable law and shall not be detrimental to CalOptima Health's best interests. Policies include the following:

   a. Disclosure of CalOptima Health Member names or Protected Health Information (PHI) is prohibited without express written permission. Images of unidentified people taken at CalOptima Health public events where no names are used are permitted.

   b. Disclosure of CalOptima Health Employee names and images is limited to pictures taken during CalOptima Health work or events that reflect positively on the organization, such as Employees posing in a professional manner at a community event.

   c. Postings that contain any product or service endorsement unrelated to CalOptima Health's programs or partnerships are prohibited.

   d. Postings that contain content that may be construed as political lobbying or solicitations for contributions are prohibited.

   e. Postings that contain disparaging remarks about politicians, political beliefs, and/or political parties are prohibited.

B. CalOptima Health Employees' Personal Social Media Sites

1. An Employee's personal social media communication that impedes performance of the Employee's job duties, interferes with the effective functioning of CalOptima Health's operations, or undermines CalOptima Health's mission is prohibited. When a nexus exists between an Employee's Social Media communication and CalOptima Health the following apply:

   a. With regards to conduct on Social Media sites, all CalOptima Health Employees are expected and required to adhere to the Employee Handbook and all CalOptima Health policies such as, but not limited to:

      i. CalOptima Health Policy GA.5005a: Use of Technology Resources

      ~~i.~~ii. CalOptima Health Policy GA.8012: Conflicts of Interest

      ~~ii.~~iii. CalOptima Health Policy GA.8022: Performance and Behavior Standards

      ~~iii.~~iv. CalOptima Health Policy GA.8025: Equal Employment Opportunity

      ~~iv.~~v. CalOptima Health Policy GA.8027: ~~Anti-~~Harassment~~-~~, Discrimination, and Retaliation Prevention

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~~v.~~vi. CalOptima Health Policy GA.8050: Confidentiality

b. CalOptima Health Employees who use Social Media should be aware of and familiar with this policy regarding CalOptima Health's official use of Online Communities and their own personal Social Media use. Failure to abide by the policy may lead to corrective action, up to and including, termination.

c. CalOptima Health Employees are prohibited from establishing a personal Social Media site representing CalOptima Health.

d. Unless a CalOptima Health Employee is serving as an approved, official spokesperson for CalOptima Health in online communications, it should be made clear to readers that the communications are the individual's personal opinions and do not reflect the opinion of CalOptima Health. CalOptima Health Employees are personally responsible for their posts, whether written, audio, video, photographs, or in any other format.

e. If Employees acknowledge their relationship with CalOptima Health in an Online Community, disclaimers shall be included in their online communications advising that they are not speaking officially on behalf of the CalOptima Health. In such situations, it is recommended that a disclaimer be used such as, "the views expressed on this blog are my own and do not reflect the views of my employer."

f. CalOptima Health Employees shall not post any material that may be reasonably understood to be defamatory, profane, obscene, threatening, harassing, abusive, discriminatory based on a protected class, embarrassing, or humiliating to another person or entity. Employees may be held personally liable for the improper use of CalOptima Health's proprietary information and defamatory or libelous commentary about CalOptima Health.

g. CalOptima Health ~~employees~~Employees and contractors shall not disclose information in connection with an information security or criminal investigation without authorization from CalOptima Health's Communication department or Legal counsel.

2. Disclosure of Member names or the posting of PHI including Member images or other identifiable information constitutes a violation of the Health Insurance Portability and Accountability Act (HIPAA) and CalOptima Health policy and confidentiality requirements. Employees will ensure that PII/PHI either on computer or in paper form are not visible in any photos or videos taken, as a measure to ensure protection of our member data. Any questions about the appropriateness of a picture to be posted shall be directed to the Communications department.

3. Disclosure of CalOptima Health Employee names and images may subject the posting Employee to corrective or legal action if rules or laws regarding confidentiality or privacy are violated. Any questions about the appropriateness of a picture of a CalOptima Health Employee shall be directed to the Communications department.

4. CalOptima Health equipment may not be utilized for personal Social Media sites. Personal Social Media use is prohibited while employee is on duty.

5. Employees are prohibited from unauthorized or unlawful use of CalOptima Health logos, trademarks or other intellectual property.

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6. Invitations to link-in to participate in non-CalOptima Health hosted sites shall be declined by Employees unless Employees are utilizing a personal computer on personal time.

7. This policy is not intended to interfere with any rights Employees may have under applicable laws.

8. Any inappropriate communications that violate this Policy should be reported to Human Resources immediately. Failure to follow this policy may result in corrective action, up to and including termination.

IV. ATTACHMENT(S)

Not applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.5005a: Use of Technology Resources
~~A.~~B. CalOptima Health Policy GA.8012: Conflicts of Interest
~~B.~~C. CalOptima Health Policy GA.8022: Performance and Behavior Standards
~~C.~~D. CalOptima Health Policy GA.8025: Equal Employment Opportunity
~~D.~~E. CalOptima Health Policy GA.8027: ~~Anti-~~Harassment, Discrimination, and Retaliation Prevention
~~E.~~F. CalOptima Health Policy GA.8050: Confidentiality
~~F.~~G. CalOptima Health Employee Handbook
~~G.A. CalOptima Health Policy GA.5005a: Use of Technology Resources~~

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2022	GA.8062	Social Media Conduct	Administrative
Revised	06/05/2025	GA.8062	Social Media Conduct	Administrative

For 20250605 BOD Review Only

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IX. GLOSSARY

Term	Definition
Employee	Any and all employees of CalOptima, including all permanent and temporary employees, volunteers, and other employed personnel.
Online Communities	~~Online Communities include~~Include, but are not limited to, postings in online forums, blogs, micro-blogs, wikis or vlogs such as Facebook, Instagram, ~~Twitter~~X, LinkedIn, MySpace, YouTube, Flickr, RSS feeds, media sites, dating sites, or similar types of online forums.
Member	A beneficiary enrolled in a CalOptima program.
Protected Health Information (PHI)	Has the meaning in Title 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a member; 2. The provision of health care to a member; or 3. Past, present, or future payment for the provision of health care to a member.
Social Media	Forms of electronic communication (such as websites for social networking and microblogging) through which users create Online Communities to share information, ideas, personal messages, and other content (such as videos).

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Policy:	GA.8062
Title:	**Social Media Conduct**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	12/01/2022
Revised Date:	06/05/2025
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250605 BOD Review Only

I. PURPOSE

This policy outlines requirements for CalOptima Health Employee communication in Online Communities and compliance with legal and regulatory requirements, including laws concerning privacy and confidentiality.

II. POLICY

A. The emergence of digital communication technologies has led to various activities that integrate technology, social interaction, and the construction of words, pictures, videos, and audio, commonly referred to as Social Media.

B. CalOptima Health recognizes that Online Communities can promote better communication with CalOptima Health Members, business partners, the public, traditional and non-traditional media, and other community stakeholders.

C. CalOptima Health's Communications department controls the content on official sites and approves the links on the CalOptima Health website.

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III. PROCEDURE

A. CalOptima Health-Hosted Social Media Sites

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applicable law and shall not be detrimental to CalOptima Health's best interests. Policies include the following:

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a. With regards to conduct on Social Media sites, all CalOptima Health Employees are expected and required to adhere to the Employee Handbook and all CalOptima Health policies such as, but not limited to:

i. CalOptima Health Policy GA.5005a: Use of Technology Resources

ii. CalOptima Health Policy GA.8012: Conflicts of Interest

iii. CalOptima Health Policy GA.8022: Performance and Behavior Standards

iv. CalOptima Health Policy GA.8025: Equal Employment Opportunity

v. CalOptima Health Policy GA.8027: Harassment, Discrimination, and Retaliation Prevention

vi. CalOptima Health Policy GA.8050: Confidentiality

b. CalOptima Health Employees who use Social Media should be aware of and familiar with this policy regarding CalOptima Health's official use of Online Communities and their own personal Social Media use. Failure to abide by the policy may lead to corrective action, up to and including, termination.

c. CalOptima Health Employees are prohibited from establishing a personal Social Media site representing CalOptima Health.

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d. Unless a CalOptima Health Employee is serving as an approved, official spokesperson for CalOptima Health in online communications, it should be made clear to readers that the communications are the individual's personal opinions and do not reflect the opinion of CalOptima Health. CalOptima Health Employees are personally responsible for their posts, whether written, audio, video, photographs, or in any other format.

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g. CalOptima Health Employees and contractors shall not disclose information in connection with an information security or criminal investigation without authorization from CalOptima Health's Communication department or Legal counsel.

2. Disclosure of Member names or the posting of PHI including Member images or other identifiable information constitutes a violation of the Health Insurance Portability and Accountability Act (HIPAA) and CalOptima Health policy and confidentiality requirements. Employees will ensure that PII/PHI either on computer or in paper form are not visible in any photos or videos taken, as a measure to ensure protection of our member data. Any questions about the appropriateness of a picture to be posted shall be directed to the Communications department.

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IV. ATTACHMENT(S)

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Not applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.5005a: Use of Technology Resources
B. CalOptima Health Policy GA.8012: Conflicts of Interest
C. CalOptima Health Policy GA.8022: Performance and Behavior Standards
D. CalOptima Health Policy GA.8025: Equal Employment Opportunity
E. CalOptima Health Policy GA.8027: Harassment, Discrimination, and Retaliation Prevention
F. CalOptima Health Policy GA.8050: Confidentiality
G. CalOptima Health Employee Handbook

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2022	GA.8062	Social Media Conduct	Administrative
Revised	06/05/2025	GA.8062	Social Media Conduct	Administrative

For 20250605 BOD Review Only

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IX. GLOSSARY

Term	Definition
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Protected Health Information (PHI)	Has the meaning in Title 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a member; 2. The provision of health care to a member; or 3. Past, present, or future payment for the provision of health care to a member.
Social Media	Forms of electronic communication (such as websites for social networking and microblogging) through which users create Online Communities to share information, ideas, personal messages, and other content (such as videos).

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Action

Approve new CalOptima Policy EE.1104: Skilled Nursing Facility Workforce and Quality Incentive Program, effective June 5, 2025.

Background

On January 13, 2025, the Department of Health Care Services (DHCS) released All-Plan Letter (APL) 25-002 Skilled Nursing Facility Workforce Quality Incentive Program. APL 25-002 provides Medi-Cal managed care plans (MCPs) with instructions on the payment and data sharing process required for the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP).

The SNF WQIP involves strict compliance requirements, including timely payment processing, provider engagement, data reconciliation, and quality metric reporting.

Discussion

CalOptima Health establishes new policies and procedures to implement federal and state laws and regulations, contractual requirements, and business practices. Additionally, CalOptima Health staff performs annual policy reviews to add or update internal procedures to ensure compliance with applicable requirements.

CalOptima Health developed Policy EE.1104: Skilled Nursing Facility Workforce and Quality Incentive Program to comply with requirements of APL 25-002. The purpose of the new policy is to outline CalOptima Health's responsibilities and processes for implementing and managing the SNF WQIP. The policy requires proper calculation and distribution of directed payments to qualifying SNF WQIP network providers, as well as timely data sharing and engagement with the providers.

The APL further requires CalOptima Health to hold webinars twice a year for SNF WQIP-eligible network providers and maintain a public website with SNF WQIP payment processes and provider grievance procedures. The new policy outlines CalOptima Health's adherence to those regulatory requirements.

Fiscal Impact

Staff anticipate that funding from DHCS will be sufficient for the SNF WQIP payments to participating facilities, with no material net fiscal impact to CalOptima Health.

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Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conduct its operations in compliance with all applicable state and federal laws and regulations, staff recommends that the CalOptima Health Board of Directors approve and adopt this new Policy EE. 1104: Skilled Nursing Facility Workforce and Quality Incentive Program.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Policy EE.1104: Skilled Nursing Facility Workforce and Quality Incentive Program
2. APL 25-002 Skilled Nursing Facility Workforce Quality Incentive Program

/s/ Michael Hunn *05/29/2025*
Authorized Signature **Date**

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Policy:	EE.1104
Title:	**Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP)**
Department:	Network Operations
Section:	Provider Relations
CEO Approval:	*/s/*
Effective Date:	06/05/2025
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☐ Covered California ☒ Medi-Cal ☐ OneCare ☐ PACE

For 20250605 BOD Review Only

I. PURPOSE

This policy is to establish CalOptima Health's responsibilities and processes for implementing and managing the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) as directed by the Department of Health Care Services (DHCS). This includes ensuring proper calculation and distribution of directed payments to qualifying SNF WQIP eligible Network Providers, timely data sharing, and Provider engagement in accordance with state and federal regulations.

II. POLICY

A. CalOptima Health shall establish clear guidelines for the timely and accurate processing of payments to SNF WQIP eligible Network Providers, including Health Networks' eligible Network Providers.

B. CalOptima Health shall commit to submission of SNF-related quality metrics alongside Medi-Cal Accountability Set (MCAS) measures, and compliance with the reporting domains encompassing workforce, clinical quality, and equity.

C. CalOptima Health shall accept, acknowledge, and resolve contracted Provider Complaints/Grievances, and Appeals in accordance with applicable statutory, regulatory, and contractual requirements through CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint, HH.1106: Pay and Educate Criteria – Provider Complaints.

D. CalOptima Health shall maintain a Long-Term Services and Supports (LTSS) liaison (described pursuant to DHCS All Plan Letter (APL) 24-009 or any superseding APL), trained and able to assist Network Providers with questions and technical assistance related to SNF WQIP in accordance with DHCS APL 25-002: Skilled Nursing Facility Workforce Quality Incentive Program. The CalOptima Health LTSS liaison shall:

1. Acknowledge receipt of communications from Network Providers within three (3) business days;

2. Serve as the point of contact for SNF WQIP; and

3. Publish the LTSS liaison's name, title, email address, and telephone number on the CalOptima Health SNF WQIP website.

E. CalOptima Health shall provide Provider communications through the CalOptima Health public website and bi-annual webinars providing updates on the program, incentive payment, quality metrics, and Grievance processes. The webinars will be presented by CalOptima Health's team via Zoom or similar electronic platforms.

III. PROCEDURE

A. CalOptima Health shall identify the qualifying Freestanding SNF Level-B and Adult Freestanding Subacute Facility Level-B facilities eligible to participate in the Medi-Cal program and that furnish services under their Network Provider Agreement with CalOptima Health or a Health Network.

B. CalOptima Health shall ensure that all delegated Health Networks understand and adhere to the requirement of registering SNFs prior to or concurrent with encounter data submission. Health Networks must complete the ACT (Add, Change, Termination) form to register for SNF Providers, in accordance with CalOptima Health Policy EE.1101: Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory.

C. CalOptima Health shall calculate the number of SNF WQIP qualifying bed days for each eligible facility including those contracted with a Health Network.

D. CalOptima Health shall make payments for qualifying bed days within forty-five (45) calendar days of receiving payment exhibits from DHCS or within thirty (30) calendar days of receiving a Clean Claim from the Provider or Health Network, whichever is later.

1. A Health Network must submit encounter data for paid SNF services for which it is financially responsible, in accordance with CalOptima Health Policy EE.1111: Health Network Encounter Reporting Requirements.

E. CalOptima Health shall recoup or withhold any amounts related to Class AA or A citations from interim and final payments.

F. CalOptima Health shall be responsible for calculating and submitting three (3) SNF WQIP specific claims-based quality metrics annually for each eligible facility in its network, aligned with the Medi-Cal Accountability Set (MCAS), and must ensure timely submission alongside MCAS data in accordance with DHCS requirements. These metrics are the three LTC report only metrics in Measurement Year 2023, 2024, and 2025.

G. CalOptima Health shall share a digitally manipulatable formatted summary level report of bed days data received from DHCS within thirty (30) days of receipt with their SNF WQIP-eligible Network Providers.

H. CalOptima Health shall confirm receipt of any discrepancy reported by a SNF WQIP-eligible Network Provider within three (3) business days.

1. CalOptima Health shall work with the SNF WQIP-eligible Network Provider to reconcile the data, which must include providing Member-level data and claims, in a machine-readable format, to the SNF WQIP-eligible Network Provider, upon request.

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I. CalOptima Health shall hold a webinar twice per year for all SNF WQIP-eligible Network Providers and shall provide the capability for Network Providers to ask live questions.

1. CalOptima Health shall post the details on the CalOptima Health website or via email communication at least thirty (30) days prior to the meeting.

J. CalOptima Health shall communicate the payment processes to SNF WQIP eligible Network Providers and maintain a SNF WQIP public internet website. The communication and website shall include, at a minimum:

1. A description of how payments will be processed;

2. How to file a Provider Grievance;

3. How to determine the responsible payer; and

4. A hyperlink to the DHCS SNF WQIP website.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Welfare & Institutions Code (W&I) § 14126.024
B. CalOptima Health Policy EE.1101: Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory
C. CalOptima Health Policy EE.1111: Health Network Encounter Reporting Requirements
D. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
E. CalOptima Health Policy HH.1106: Pay and Educate Criteria – Provider Complaints
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-009: Skilled Nursing Facilities- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 23-004)
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 25-002: Skilled Nursing Facility Workforce Quality Incentive Program

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
TBD	Department of Health Care Services (DHCS)	TBD

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/05/2025	EE.1104	Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP)	Medi-Cal

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IX. GLOSSARY

Term	Definition
Appeal	A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a Covered Service, except payment denials based solely because the claim does not meet the definition of a Clean Claim; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Clean Claim	A claim that can be processed without obtaining additional information from the Provider or from a third-party, including invoices that meet DHCS established billing and invoicing requirements.
Complaint	A complaint is the same as a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance.
Department of Health Care Services (DHCS)	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.
Grievance	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 CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health 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 CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Network Provider	Any Provider or entity that has a Network Provider Agreement with CalOptima Health or CalOptima Health's Subcontractor(s) and receives Medi-Cal funding directly or indirectly to order refer or render Covered Services under the contract between said parties. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.

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Term	Definition
Provider	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.
Skilled Nursing Facility (SNF)	Any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal program.

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For 20250605 BOD Review Only

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: January 13, 2025

ALL PLAN LETTER 25-002

TO: ALL MEDI-CAL MANAGED CARE PLANS[1]

SUBJECT: SKILLED NURSING FACILITY WORKFORCE QUALITY INCENTIVE PROGRAM

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with instructions on the payment and data sharing process required for the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) for Rating Periods between January 1, 2023, and December 31, 2026. The Calendar Year (CY) 2023 Rating Period is referred to as Program Year (PY) 1, CY 2024 Rating Period as PY 2, and so forth.

BACKGROUND:
Assembly Bill (AB) 186 (Chapter 46, Statutes of 2022) amended the Medi-Cal Long-Term Care Reimbursement Act to reform the financing methodology applicable to Freestanding SNFs Level-B and Adult Freestanding Subacute Facilities Level-B.[2] AB 186 added Welfare & Institutions Code (W&I) section 14126.024 authorizing the state to implement SNF WQIP, which will provide performance-based directed payments to facilities to incentivize workforce and quality improvements. SNF WQIP succeeds the former Fee-For-Service (FFS) delivery system's Quality and Accountability Supplemental Payment (QASP) program.

As of January 1, 2023, all MCPs are responsible for SNF long-term care (LTC) services pursuant to W&I section 14184.201. Prior to January 1, 2023, only MCPs operating in County Organized Health Systems or Cal MediConnect (Coordinated Care Initiative) counties were responsible for LTC services on a long-term basis, and other MCPs covered those services only for the initial month of admission and subsequent month, after which those Members were disenrolled from Medi-Cal managed care and covered through Medi-Cal FFS.

POLICY:
SNF WQIP-Eligible Network Providers and Bed Days
Qualifying Freestanding SNF Level-B and Adult Freestanding Subacute Facility Level-B facilities eligible to participate in the Medi-Cal program and that furnish services under a

[1] This APL does not apply to Prepaid Ambulatory Health Plans.
[2] State law is searchable at: https://leginfo.legislature.ca.gov/.

Network Provider Agreement.[3] Pursuant to W&I section 14126.024(d) and (l)(3), freestanding pediatric subacute care facilities, intermediate care facilities for the developmentally disabled homes, distinct part facilities, and SNFs with 100% designated special treatment program beds are not eligible for SNF WQIP. MCPs are responsible for determining if a Network Provider is eligible to participate in SNF WQIP.

SNF WQIP qualifying bed days are calendar days during which a Member receives SNF Level-B services inclusive of the first day of a Member's stay and excluding the day of discharge unless it is also the first day of stay, rendered during the PY and billed under a Network Provider Agreement with an MCP pursuant to applicable state and federal laws, regulations, and contractual terms for which Medi-Cal is the primary payer and where Medicare is no longer covering any portion of the bed day. SNF Level-B services are defined in Title 22 California Code of Regulations (CCR) sections 51123(a), 51511(b), 51535, and 51535.1 as applicable and include:[4]

- SNF services as set forth in Title 22 CCR section 51123(a):
  - Room and board.
  - Nursing and related care services.
  - Commonly used items of equipment, supplies, and services as set forth in Title 22 CCR section 51511(b).
- Leave-of-absence days as set forth in Title 22 CCR section 51535.
- Bed holds as set forth in Title 22 CCR section 51535.1.

Pursuant to W&I section 14126.024(e), bed days receiving reimbursement for special treatment program (STP) services for the mentally disordered are not qualified for SNF WQIP payments. Furthermore, hospice bed days are not qualified for SNF WQIP. Facilities in which all beds are designated for STP and/or hospice services thus are not qualified for SNF WQIP.

Bed days reimbursed outside of a Network Provider Agreement, bed days for which Medi-Cal is a secondary payer, and bed days reimbursed through the Medi-Cal FFS delivery system are not qualified for SNF WQIP.

Payments to SNF WQIP-Eligible Network Providers

SNF WQIP payments will be made by MCPs to SNF WQIP-eligible Network Providers based on an interim and final per diem amount calculated by the Department of Health Care Services (DHCS) in accordance with the preprint approved by the Centers for Medicare & Medicaid Services (CMS) and DHCS' SNF WQIP Technical Program

[3] For more information on evaluating Network Provider status, see APL 19-001 or any superseding APL. APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[4] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.

Guide.[5] For each PY, DHCS will aim to calculate quality scores and provide payment exhibits directing MCPs to pay the interim per diem amount during the first part of the CY following the Rating Period, and the final per diem amount during the second part of the CY following the Rating Period.

MCPs are responsible for calculating the number of SNF WQIP qualifying bed days and paying the directed per diem amount for all clean and complete SNF WQIP qualifying bed days without regard to when these bed days are reported to DHCS consistent with any reporting requirements applicable to the SNF.

MCPs are responsible for netting out any previously directed interim payment amounts from the final payment. MCPs are responsible for recouping or withholding any amounts related to Class AA or A citations from interim and final payments as described below.

MCPs must make payments to SNF WQIP-eligible Network Providers for qualifying bed days within 45 calendar days of receiving payment exhibits from DHCS or within 30 calendar days of receiving a Clean Claim from the Provider, whichever is later.

Class AA and A Citations

In accordance with the SNF WQIP program's requirements, MCPs must withhold SNF WQIP payments for facilities with one or more Class AA or A citations issued by the California Department of Public Health (CDPH) for violations that occur wholly or in part during the PY.

- Class AA citations are issued to facilities for actions that are the proximate cause of resident death. Facilities with one or more class AA citations partly or wholly in the PY are disqualified from payments for that PY.
- Class A citations are issued to facilities for actions where there is imminent danger of death or serious harm to a resident or a substantial probability of death or serious physical harm. Facilities with one or more class A citations partly or wholly in the PY receive a 40 percent penalty to the per diem payment amount for that PY.

CDPH publishes state enforcement action data, including Class AA and A citations, on the CDPH State Enforcement Actions Dashboard.[6] If an MCP becomes aware of an applicable citation for a PY after the time of an interim or final payment, the MCP must recoup and withhold the applicable payments retroactively for the respective PY.

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[5] The SNF WQIP Technical Program Guide for PY1 is available at: https://www.dhcs.ca.gov/services/Documents/WQIP-PY1-TechnicalProgramGuide-F3.pdf.

[6] The CDPH State Enforcement Actions Dashboard is available at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/StateEnforcementActionsDashboard.aspx.

For citations that are appealed, MCPs must withhold the applicable payments until all appeals are exhausted and, if applicable, release the applicable payments based on the final disposition of the citation, without regard to the length of the appeals process.

Separate Payment Term

For PY 1, DHCS will calculate the final separate payment term made by DHCS to MCPs based on qualifying bed days that are reported by MCPs to the Post-Adjudicated Claims and Encounters System (PACES) by October 15, 2024, and that are accepted by DHCS. For PY 2 and subsequent PYs, DHCS will calculate the final separate payment term made by DHCS to MCPs based on qualifying bed days that are reported by MCPs to PACES by June 30 following the PY and that are accepted by DHCS.

Because Providers generally have up to 12 months to report claims to MCPs, DHCS may make actuarially appropriate adjustments to reflect claims run out past the reporting deadline. However, the inclusion, or lack thereof, of SNF WQIP qualifying bed days in the data reported to DHCS does not impact the MCP's obligation to make payments for all SNF WQIP qualifying bed days.

WQIP Score & Quality Metrics

DHCS will calculate each SNF WQIP-eligible Network Provider's performance metrics, WQIP score, and resulting interim and final per diem payment amounts. For PY 1, PY 2, and PY 3, SNF WQIP includes several quality metrics across workforce, clinical, and equity domains. An aggregate curve factor is applied to all facilities' WQIP scores based on projected qualifying bed days to calculate the interim and final per diem payment amounts. Because a single facility may have bed days billed to multiple MCPs, DHCS will calculate the aggregate performance on each metric and the curve factor across all MCPs.

SNF WQIP includes three claims-based clinical quality metrics that MCPs must calculate on behalf of SNF WQIP-eligible Network Providers. These metrics are the three LTC report only metrics in Measurement Year 2023, 2024, and 2025 of the Medi-Cal Accountability Set (MCAS).[7] The specifications for the SNF WQIP versions of these metrics are provided in the SNF WQIP Technical Program Guide. The SNF WQIP versions of these LTC metrics are sub-sets of the MCP's overall performance on these measures (e.g., the MCP reports their overall performance through MCAS and a sub-rate for each SNF WQIP-eligible facility that is a Network Provider). MCPs must submit the SNF WQIP versions of these LTC metrics at the same time MCAS data are due for each MCAS Measurement Year as described in APL 24-004 or any superseding APL.

[7] The MCAS measures for each measurement year are available at: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEAS.aspx.

Additionally, for PY 1, PY 2, and PY 3, the Medi-Cal Disproportionate Share metric counts all Medi-Cal bed days including contracted and non-contracted bed days in the managed care delivery system and bed days in the FFS delivery system.

DHCS will calculate the interim curve factor based on qualifying bed days that are reported by MCPs to PACES by December 31 of the PY and that are accepted by DHCS. DHCS will calculate the Medi-Cal Disproportionate Share metric and final curve factor based on qualifying bed days that are reported by MCPs to PACES by June 30 following the PY and that are accepted by DHCS.

Bed Days Data Sharing

DHCS will provide MCPs with data reflecting all SNF bed days reported by MCPs to PACES on a quarterly basis as described in Appendix A below. MCPs must reconcile the data against the MCP's records and provide each SNF WQIP-eligible Network Provider with a summary level reporting including the specified data fields in Appendix A. These summary level reports must be sent to all SNF WQIP-eligible Network Providers in a manipulatable digital format within 30 calendar days of receiving the data from DHCS. If a SNF WQIP-eligible Network Provider reports a possible discrepancy in the summary level report, the MCP must confirm receipt of the inquiry within three business days and work with the Network Provider to reconcile the data, which must include providing Member-level data and claims, in a machine readable format, to the Network Provider upon request.

General Provisions

MCPs must have a formal procedure to accept, acknowledge, and resolve Network Provider grievances related to the processing or non-payment of SNF WQIP directed payments including the calculation of SNF WQIP qualifying bed days. DHCS may request information regarding the Network Provider grievances and how they were resolved. MCPs must maintain records to respond to DHCS's request for information regarding Network Provider grievances.

MCPs must communicate the payment processes to SNF WQIP-eligible Network Providers and maintain a SNF WQIP public internet website. The communication and website must, at a minimum, include a description of how payments will be processed, how to file a Provider grievance, how to determine the responsible payer, and a hyperlink to the DHCS SNF WQIP website.[8]

[8] The DHCS SNF WQIP website is available at: https://www.dhcs.ca.gov/services/Pages/SNF-WQIP.aspx.

MCPs must ensure that Long-Term Services and Supports (LTSS) liaisons (described pursuant to APL 24-009 or any superseding APL) are trained and able to assist Network Providers with questions and technical assistance related to SNF WQIP. Liaisons must acknowledge receipt of communications from Network Providers within three business days. MCPs with more than one LTSS liaison must designate at least one of the LTSS liaisons to act as the point of contact for SNF WQIP. MCPs must publish the LTSS liaison's name, title, email address, and telephone number on the MCP's SNF WQIP public internet website.

Each MCP must hold a webinar twice per year for all SNF WQIP-eligible Network Providers. The webinar must allow these Network Providers to participate virtually via telephone and optionally via an online teleconference service. The webinar must provide the capability and opportunity for Network Providers to ask live questions. If an MCP covers multiple counties, a single webinar can be held for all counties. If a single county/region has multiple MCPs, the MCPs may hold joint webinars to satisfy this requirement, though each individual MCP must answer questions from Network Providers about issues specific to that individual MCP. At least 30 days before the webinar, each MCP must publish, on its SNF WQIP public internet website, the date and time of the webinar and instructions to join and notify DHCS and all SNF WQIP-eligible Network Providers. DHCS may provide additional guidance to MCPs regarding the required timing, content, and duration of webinars.

The requirements in this APL necessitate a change in MCPs' contractually required policies and procedures (P&Ps). MCPs must submit their updated P&Ps to their Managed Care Operations Division (MCOD)-MCP Submission Portal[9] within 90 days of the release of this APL.

MCPs are responsible for ensuring that all Subcontractors, Downstream Subcontractors, and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all Subcontractors, Downstream Subcontractors, and Network Providers. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. MCPs should review their Network Provider and/or Subcontractor Agreements, including Division of Financial Responsibility provisions as appropriate, to ensure compliance with this APL. For additional information regarding administrative and monetary sanctions, see APL 23-012, and any subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions.

[9] The MCOD-MCP Submission Portal can be found at: https://cadhcs.sharepoint.com/sites/MCOD-MCPSubmissionPortal/SitePages/Home.aspx.

For MCPs that have any questions regarding this APL, please contact your MCOD Contract Manager and Capitated Rates Development Division Rate Liaison. For SNFs that have any questions regarding this APL, please contact SNFWQIP@dhcs.ca.gov.

Sincerely,

Original Signed by Bambi Cisneros

Bambi Cisneros
Acting Chief, Managed Care Quality and Monitoring Division
Assistant Deputy Director, Health Care Delivery Systems

Appendix A

Data Sharing:
DHCS will provide a dataset containing the below data elements to each MCP. Each MCP must reconcile the data against the MCP's records and provide each of their SNF WQIP-eligible Network Provider with summary-level reporting containing at least the following data fields:

- Plan_Name
- PLAN_CD
- Facility_Name
- NPI
- PROV_274
- MEDICARE_IND
- Medicare_Status
- Remove_Days
- Remove_Note
- WQIP_Days

Data Description:
The data reflects claims that fall under the LTC category of service, based on Mercer's Rate Development Template (RDT) logic.

SNF WQIP qualifying bed days are derived as follows:

Also, bed days are only counted if they fall within the PY. For example, CY 2023 SNF WQIP qualifying bed days for an LTC claim would be calculated as:

SNF WQIP Bed Days = (minimum of SVC_TO_DT or 12/31/2023) - (max of SVC_FROM_DT or 1/1/2023) + 1 (only if LTC claim is non-discharge)

1 bed day is counted in instances where SVC_FROM_DT = SVC_TO_DT

Otherwise, the discharge date does not count towards payable days.

Additionally, bed days for Medicare crossover claims (MEDICARE_IND = "1") where the beneficiary has Medicare Part A coverage are not qualified for SNF WQIP.

Data Fields:

Field Name	Description
Plan_Name	health plan name
PLAN_CD	health plan code
Facility_Name	facility name
NPI	billing provider's National Provider Identifier number
PROV_274	DHCS derived field indicating whether provider (based on NPI) is a Network Provider identified in the health plan's Network Provider file
RECORD_ID	record identification number, provides a unique number for each claim header record
MAIN_SGMNT_ID_NO	claim line number
AKA_CIN	beneficiary's client index number
ENCRYPTED_AKA_CIN	encrypted client index number
BENE_FIRST_NAME	beneficiary's first name
BENE_LAST_NAME	beneficiary's last name
AGE	beneficiary's age
BIRTH_DT	beneficiary's birth date
CLAIM_FORM_IND	indicates whether claim form used is a UB-04 or a HCFA-1500 form
FI_CLAIM_TYPE_CD	claim type code
FI_PROV_TYPE_CD	provider type code
PROV_TAXON	billing provider taxonomy
SVC_FROM_DT	header level service from date
SVC_TO_DT	header level service to date
INPAT_DISCHARGE_DT	date the patient was discharged (inpatient/LTC claims only), equals SVC_TO_DT when not blank
INPAT_DISCHARGE_CD	value of 6 indicates non-discharge claim
Day_DIFF	day difference = (minimum of SVC_TO _DT or program phase end date) - (max of SVC_FROM_DT or program phase start date) + 1 (only if LTC claim is non-discharge) 1 bed day is counted when SVC_FROM_DT = SVC_TO_DT
DTL_SVC_FROM_DT	detail level service from date
DTL_SVC_TO_DT	detail level service to date
ORIG_POS_CD	place of service code

Field Name	Description
PROC_CD	procedure code
REND_OPERATING_PROV_TAXON	rendering provider taxonomy
REVENUE_CD	revenue code
MEDICARE_IND	value of 1 indicates Medicare crossover claim
MC_STAT_A	code indicating status and funding source for beneficiary's Medicare Part A coverage
MC_STAT_B	code indicating status and funding source for beneficiary's Medicare Part B coverage
Medicare_Status	field derived from eligibility data indicating beneficiary's Medicare coverage status
Remove_Days	indicates how many days have been zeroed out due to Medicare Part A exclusion
Remove_Note	indicates if days were not qualified for SNF WQIP due to being for Medicare crossover claims where the beneficiary has Medicare Part A coverage
WQIP_Days	set equal to Day_DIFF on the first claim line of each LTC claim

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

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

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Action
Approve new CalOptima Health Policy EE.1146: Provider Directory, effective April 1, 2025.

Background
Provider directory requirements were previously part of CalOptima Health Policy EE:1101: Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory.

Staff created the new Policy EE.1146 Provider Directory (Policy EE.1146) with the purpose of focusing on requirements related to provider directories for Medi-Cal and OneCare programs, and, effective 2027, the Covered California program.

Discussion
The new Policy EE.1146 provides greater clarification on the directory maintenance and production processes to reflect current and new regulations. Updates in the new policy include:

- Categorizing and detailing the end-to-end process from data collection to validation and publication.
- Specifying requirements and timelines for directory submissions to regulators, including the Department of Health Care Services, Centers for Medicare & Medicaid Services, Department of Managed Health Care, and Covered California (the latter of which is effective in 2027).
- Addresses National Committee for Quality Assurance (NCQA) Health Equity requirements for capturing and displaying information related to provider's language proficiency when speaking to members about their care, provider staff languages, offices language services, and provider race and ethnicity where the provider has the option to share such information.
- Other non-substantive changes (*i.e.*, formatting, clarifying languages, grammatical changes, document flow).

Staff requests CalOptima Board of Director (Board) approval of new CalOptima Health Policy EE.1146: Provider Directory that dedicates a policy specific to requirements for provider directories maintenance and accessibility for all lines of business. The policy effective date reflects CalOptima Health's implementation of NCQA Health Equity requirements in April 2025.

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Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2024-25 Operating Budget.

Rationale for Recommendation
To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, staff recommends that the CalOptima Health Board approve and adopt CalOptima Health Policy EE.1146: Provider Directory.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Policy EE.1146: Provider Directory

/s/ Michael Hunn *05/29/2025*
Authorized Signature **Date**

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Policy:	EE.1146
Title:	**Provider Directory**
Department:	Provider Data Operations
Section:	Provider Data Management Services
CEO Approval:	*/s/*
Effective Date:	04/01/2025
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☐ PACE

(Language included in this policy for the Covered California program is not in effect until 01/01/2027)

For 20250605 BOD Review Only

I. PURPOSE

The purpose of this policy is to establish procedures for managing and publishing the CalOptima Health Provider Directory. This includes ensuring the accuracy of Provider information through access, verification, validation, collection, and evaluation across both printed formats and the web-based Provider Directory, in compliance with applicable regulations.

II. POLICY

A. The Provider Directory shall include information on healthcare Providers such as Health Networks, Facilities, hospitals, Primary Care Providers (PCPs), OB/GYNs, specialists, behavioral health Providers, vision Providers, urgent care centers, and other credentialed Providers with CalOptima Health, either directly or through a subcontracted agreement.

B. For each CalOptima Health program, a printed hardcopy and an online PDF version of the Provider Directory shall be published monthly and accessible through the CalOptima Health website. The online PDF version will be easily accessible for users through a dedicated section of the website. The Online PDF version shall be made available in machine-readable format, in accordance with Title 42 of the Code of Federal Regulations, section 438.10(h)(4), and section 1367.27(c)(2) of the California Health and Safety Code.

1. All versions of the Provider Directory will include clear instructions on how to use the directory. These instructions will:

   a. Explain any acronyms and symbols used.

   b. Provide guidance on how to utilize CalOptima Health services.

   c. Include contact information for assistance. These instructions will be in alignment with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

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2. Additionally, the Provider Directory will list the physical accessibility features of providers, in accordance with CalOptima Health Policy GG.1608: Full Scope Site Review, Department of Health Care Services (DHCS), All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule, and Medi-Cal Managed Care Division (MMCD) Policy Letter (PL) 11-009: Update to Policy Letter 00-002: Update to Health Plan Provider Directory Policy and Guidelines.

C. For each CalOptima Health program, the Web-based, a printed hardcopy, and the online PDF version of the Provider Directory shall provide information on available interpreter services at no cost to Members, along with easily accessible contact resources for requesting language assistance in accordance with CalOptima Health Policy DD.2005: Member Informing Materials Requirements.

D. CalOptima Health shall maintain a process that allows Providers to submit verifications or Changes to their listed information, ensuring accuracy and compliance with the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and Covered California guidance. Providers must comply with this policy, which mandates Providers to keep their information current, accurate, and submit any necessary updates in accordance with the timelines set forth and in accordance with CalOptima Health Policy EE.1101: Additions, Changes, and Terminations to CalOptima Health Provider Information.

E. CalOptima Health and Health Networks are responsible for updating the Provider demographic data for all versions of the Provider Directory with new or revised information received from the Providers and their representatives.

F. The Web-based Provider Directory shall be updated within forty-eight (48) hours after the request to Add, Change, or Terminate a Provider is completed. Updates will be reflected in the printed and PDF format within thirty (30) calendar days.

G. CalOptima Health shall investigate reported inaccuracies in the Provider Directory, contacting affected Providers within five (5) business days and updating the information within thirty (30) calendar days if inaccuracies are confirmed.

H. CalOptima Health shall ensure all versions of the Provider Directory comply with the requirements set forth by the Centers for Medicare & Medicaid Services (CMS), Covered California, DHCS, and DMHC.

I. CalOptima Health shall submit the Medi-Cal Provider Directory to DHCS every six (6) months, including an online PDF version, and address any findings from DHCS's reviews within the specified timeframe.

J. CalOptima Health shall submit the outline of the OneCare Provider and Pharmacy Directory printed format to DHCS and CMS for annual approval.

K. CalOptima Health shall make its Covered California provider directory available to Covered California electronically for publication online in accordance with guidance from Covered California.

L. CalOptima Health shall submit provider directory information to Covered California in a format prescribed by Covered California on a monthly basis to support Covered California's centralized provider directory.

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M. CalOptima Health shall ensure all versions of the Provider Directory comply with relevant regulations including maintaining an Application Programming Interface (API), in accordance with Title 42 of the Code of Federal Regulations (CFR) § 438.10(h)(3), Health and Safety Code § 1367.27, and DHCS All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule.

N. Consistent with the requirements of DHCS APL 22-026 and the CMS Interoperability and Patient Access Final Rule, the following provisions shall be implemented:

1. CalOptima Health and Health Networks shall conduct routine testing, monitoring, and system updates to ensure that all required APIs function properly, remain secure, and provide accurate data in real time or within required timeframes.

2. CalOptima Health and Health Networks shall attest to meeting all Provider Directory API requirements and submit such attestations as outlined in APL 22-026 and related DHCS guidance.

3. CalOptima Health and Health Networks reserve the right to deny or discontinue any third-party application's connections to an API if it is reasonably determined—consistent with the security risk analysis under the HIPAA Security Rule—that continued access presents an unacceptable risk to the security of protected health information (PHI) on CalOptima Health's systems.

    a. Any decision to deny or discontinue a third-party application's API access shall be based on objective, verifiable criteria that are applied fairly and consistently across all applications and developers.

4. CalOptima Health and Health Networks shall demonstrate their ability to comply with interoperability requirements by submitting readiness, implementation, and ongoing deliverables to DHCS, as directed and in accordance with APL 22-026.

O. CalOptima Health, Health Networks, Delegated Provider Groups, and Providers shall validate their directory information on a semi-annual basis in accordance with this policy.

1. Additionally, this information will be available in all Threshold Languages.

P. CalOptima Health shall ensure that all Members, prospective Members, Providers, and members of the public have access to information from the CalOptima Health Provider Directory and Web-based Directory in alternate media formats upon request and that all Members have full and equal access to Covered Services, regardless of disability status, in accordance with applicable nondiscrimination laws and accessibility standards.

Q. CalOptima Health shall maintain Provider Directory information in accordance with applicable state and federal regulations, including but not limited to DMHC all plan letters (APLs), the Uniform Provider Directory Standards, and California Health and Safety Code section 1367.27. The directory shall accurately reflect provider participation, modality of care, and service availability across all lines of business.

1. In limited circumstances, and with appropriate documentation, CalOptima Health may omit physical address information when consistent with regulatory allowances, including considerations related to provider safety or non-traditional care delivery settings.

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2. For providers who offer services exclusively through telehealth or in community-based or mobile settings without a fixed location, CalOptima Health may represent service availability through geographic descriptors such as “Serving Orange County” and include the appropriate modality of care and contact details.

III. PROCEDURE

A. Provider Data Collection

1. CalOptima Health maintains a process and system by which Providers may submit verification or Changes to their listed information in both printed formats and the Web-based Provider Directory in a manner consistent with guidance from the DHCS, DMHC, Covered California, and applicable contractual obligations.

   a. Providers may submit Changes via the Addition, Change, Termination (ACT) form (Attachment A) or via email to the Provider Data Operations (PDO) Department.

   b. Updates will be processed and reflected in the printed hardcopy and online PDF format versions of the Provider Directory within thirty (30) calendar days of submission to ensure accuracy of the information.

   c. The Web-based Provider Directory demographic data shall be reflected with updated information within forty-eight (48) hours following the processing of an ACT form or a demographic change request.,

   d. All submissions shall include essential information such as Provider identification, contact details, affiliation, services provided, panel status, and relevant data required by applicable laws, regulatory guidance, and CalOptima Health business needs.

   e. All records will be maintained and stored within the CalOptima Health database system.

   f. Providers shall request the omission of their information and/or address from the CalOptima Health Provider Directory by submitting a written request to CalOptima Health. Such requests should include a general explanation for the omission. CalOptima Health will review these requests in accordance with applicable regulatory requirements and may consult with relevant oversight agencies as necessary.

B. Listing of Provider Types in the Provider Directories.

1. CalOptima Health contracts with various Providers to deliver health care services to Members. The following Provider types are examples of what will be included in the Provider Directory across all programs:

   a. Physicians and surgeons;

   b. Allied Health Professionals (e.g., nurse practitioners, psychologists, chiropractors, nurse practitioners, psychologists, chiropractors, acupuncturists, optometrists, podiatrists, doulas, nurse midwives, dentists, qualified autism service providers, licensed clinical social workers, marriage and family therapists, professional clinical counselors);

   c. Health Facilities: (e.g., Federally Qualified Health Centers, Indian Health Facilities, Rural Health Clinics);

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d. Facilities and Hospitals (e.g., general acute care hospitals, skilled nursing facilities); and

e. Additional Service Facilities (e.g., pharmacies, laboratories, imaging centers, dialysis centers).

C. Provider Directory Data Elements.

1. All versions of Provider Directory shall include information on Providers as required by regulations and business needs. Key data elements requirements are in Table 1: Provider Directory Data Requirements.

2. The provider directory shall display the date the directory was most recently updated.

3. The directory shall also display a telephone number, dedicated email address, and reporting form hyperlink for Members to report of possible inaccurate, incomplete, or misleading directory information.

4. The Covered California directory shall also state a Member may submit a complaint if the Member believes they reasonably relied upon materially inaccurate, incomplete, or misleading directory information.

D. Publication and Access.

1. CalOptima Health shall publish a printed hard copy and an online PDF version of the Provider Directory for each program monthly. The online PDF will be accessible via CalOptima.org. The online PDF shall meet the required accessibility web standards (e.g. Section 508 compliances, Web Content Accessibility Guidelines (WCAG) 2.0).

2. The Provider Directory shall support search functionality that enables Members and the public to identify and locate participating Providers and Facilities through a user-friendly interface. The search tool shall allow for a reasonable combination of search criteria and filters to facilitate accurate and efficient results. At a minimum, search capabilities shall include:

a. Search by product line, Provider name, Provider type, ZIP code, or any combination of these elements.

b. If both a Provider's preferred name and licensed name are displayed, the directory shall allow searches to return results using either name, consistent with applicable regulatory standards.

3. Provider Directory Access.

a. Providers, Members, and potential Members can access the CalOptima Health Provider Directory for their specific line of business, including Covered California, Medi-Cal, and Medicare, through the following methods.

i. Online Access: The current monthly publication of the online PDF, along with the web-based Provider Directory, is available on the CalOptima Health website CalOptima.org.

ii. Request for Printed Copy: A hard copy of the Provider Directory may be requested by contacting CalOptima Health's Customer Service Department by phone, through

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the member portal, by email, or by mailing a written request. The printed copy will be mailed within five (5) business days.

iii. Telephone Assistance: Members may contact the Customer Service line for assistance, where Customer Service Representatives are available to help by utilizing the Web-Based Provider Directory, guiding Members on how to access the Provider Directory, ordering hard copies of the Provider Directory, and requesting alternative formats to be sent by U.S. Mail.

iv. Members may also contact CalOptima Health Customer Service to request additional information about a Provider, including race/ethnicity, education, training, and other relevant attributes, in accordance with NCQA Member Experience (ME) 2, Element A, Factor 7 of the 2024 HP Standards and Guidelines.

E. Provider Directory Validation and Attestation.

CalOptima Health and Health Networks will conduct comprehensive audits and updates of the Provider Directories to ensure accuracy. The process includes the following steps:

1. CalOptima Health shall distribute a Provider Data Universe report to CalOptima Health Community Network (CHCN) and Health Networks semiannually.

2. Providers are required to confirm or update their demographic details through various modalities (e.g., fax, email, phone)

3. Providers shall be notified of their obligation to maintain current information by CalOptima Health or delegated representatives. All contracted Providers not accepting new Members must direct Members or potential Members to CalOptima Health for assistance and reporting of inaccuracies.

4. If any discrepancies are identified during the review, CalOptima Health, CHCN, and Health Networks shall promptly verify, correct the information, and submit a change request to CalOptima Health.

5. If a provider (excluding general acute care hospitals) does not respond within thirty (30) business days to directory verification outreach, CHCN and Health Networks shall initiate verification efforts within the following fifteen (15) business days. If the provider's information cannot be verified, CHCN and Health Networks shall send a ten (10) business-day notice to the provider prior to removing the provider from the Provider Directory. The provider may avoid removal by responding within that notice period.

6. In accordance with annual requirements from DHCS, Health Networks and CHCN shall require Medi-Cal Providers to validate and attest to the accuracy of their demographic data. Providers must submit written confirmations, which will be collected and submitted to the Provider Data Operations Department (PDO). This documentation will be stored in the PDO system for retrieval and reference. Health Networks and CHCN shall store written Provider's attestations for a minimum of ten (10) years.

7. CalOptima Health shall maintain a documented process for Members, Providers, and stakeholders to report potential inaccuracies in the Provider Directory. Reports may be submitted via telephone, email, or through an online form accessible on the CalOptima Health website. Reported inaccuracies shall be investigated within thirty (30) calendar days, and if confirmed, updates shall be made to the web-based Provider Directory no later than

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the next scheduled weekly update, or sooner if required by applicable regulations, and to the printed and PDF versions no later than the next scheduled monthly update, or sooner if required by applicable regulations, in accordance with National Committee of Quality Assurance (NCQA), Health Plan (HP) Standards and Guidelines, NET 5, Element D, Factor 1; and California Code, Health & Safety Code §1367.27.

a. Members may also contact DHCS Medi-Cal Managed Care Office of the Ombudsman at 1-888-452-8609 or MMCDOmbudsmanOffice@dhcs.ca.gov if concerns about the Medi-Cal Provider Directory are not resolved.

F. Regulatory Submission.

CalOptima Health is responsible for submitting Provider Directory policies, procedures, and data to applicable regulatory agencies, in accordance with federal and state requirements.

1. Medi-Cal (DHCS):
Semiannually, CalOptima Health shall submit the Medi-Cal Provider Directory Data and the PDF Provider Directory every six (6) months to DHCS, in accordance with DHCS APL 22-026: Interoperability and Patient Access Final Rule.

a. Additionally, CalOptima Health shall submit the Medi-Cal PDF version of the Provider Directory to DHCS monthly.

b. CalOptima Health shall address any findings from DHCS's Provider Directory reviews with the specified timeframe.

2. Medicare Advantage (CMS and DHCS):
Annually, CalOptima Health shall submit the Provider Directory for OneCare Complete and Flex Plan to DHCS and CMS for review and approval.

a. The Provider Directory will be made available during the open enrollment period for both potential and current Members to support decision-making regarding available Providers and covered services.

3. DMHC:
Annually, CalOptima Health shall submit its Provider Directory policies and procedures to the DMHC, in accordance with DMHC's latest APL requirements.

4. Covered California (Effective 2027):
Monthly, CalOptima Health shall submit Provider Directory data to Covered California, in a format prescribed by Covered California, to support its centralized online Provider Directory.

G. Review of Web-based Provider Directory

CalOptima Health shall evaluate the usability of its web-based Provider Directory every three (3) years and determine required improvement. The assessment will include the following criteria, in accordance with NCQA, HP Standards and Guidelines, NET 5 I, Directory Usability Survey:

1. Reading Level: Evaluate the readability of the content to ensure it is accessible to all users.

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2. Content Organization: Assess the intuitive organization of content to facilitate user understanding and engagement.

3. Navigation Ease: Examine the ease of navigation within the tool to enhance user experience.

4. Language Accessibility: Review the availability of directories in additional languages, as applicable to the Members population, if applicable to Members.

Table 1: Provider Directory Data Requirements

Provider Data Elements	Type	Printed/PDF Directory			Web-based Directory		
		Medi-Cal	OneCare	Covered California (Effective: 2027)	Medi-Cal	OneCare	Covered California
Headers to indicate City Name (in alphabetical order)	Practitioner Facility	Required	Required	If applicable	If applicable	If applicable	If applicable
Specialty (e.g. Family Medicine) including board certification if any	Practitioner Facility	Required	Required	Required	Required	Required	Required
Provider Name	Practitioner Facility	Required	Required	Required	Required	Required	Required
Alternative/ Preferred Name	Practitioner Facility	If applicable	If applicable	If applicable	If applicable	If applicable	If applicable
Assigned Provider Identification	Practitioner Facility	Required	Required	If applicable	Required	Required	If applicable
Gender	Practitioner	Not required	Not required	Not required	Required	Required	Not required
Taxonomy	Practitioner Facility	If applicable	If applicable	Not required	If applicable	If applicable	Not required
California License number and or type of license	Practitioner Facility	If applicable	If applicable	Required	If applicable	If applicable	Required
Board certified	Practitioner	If applicable	If applicable	Required	If applicable	If applicable	Required
National Provider Identifier (NPI) Number Type 1 or Type 2	Practitioner Facility	Required	Required	Required	Required	Required	Required
Primary care clinic or Medical Group affiliations	Practitioner Facility	If applicable	If applicable	Required	If applicable	If applicable	Required
Age Restriction (Member age minimum, Member age maximum, gender restrictions)	Practitioner Facility	Not required	Not required	Not Required	If applicable	If applicable	Not Required
Listing of languages spoken by the practitioner, including their fluency in	Practitioner	Required *If applicable	Required *If applicable	Required	Required	Required	Required

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Provider Data Elements	Type	Printed/PDF Directory			Web-based Directory		
		Medi-Cal	OneCare	Covered California (Effective: 2027)	Medi-Cal	OneCare	Covered California
communicating medical care*, such as American Sign Language (ASL) and any other languages besides English							
Listing of languages spoken by Staff, including American Sign Language (ASL) and other languages besides English	Practitioner Facility	If applicable	If applicable	If applicable	If applicable	If applicable	If applicable
Language services availability at practice location (Including Non-English language spoken by a medical professional, or qualified medical interpreter)	Practitioner Facility	If applicable	If applicable	If applicable	If applicable	If applicable	If applicable
Practitioner Race/Ethnicity	Practitioner	If applicable	If applicable	If applicable	If applicable	If applicable	If applicable
Gender-Affirming Services	Practitioner	If applicable	Not Required	Not Required	If applicable	Not Required	Not Required
Telehealth Provider and site indicators: Only Telehealth, No Telehealth (only in-person), or Both Telehealth and in-person	Practitioner Facility	Required	Required	Required	Required	Required	Required
Practice Address, City, State, and Zip Code (including suite number)	Practitioner Facility	Required	Required	Required	Required	Required	Required
Telephone number (including area code)	Practitioner Facility	Required	Required	Required	Required	Required	Required
After-hours Telephone Number	Practitioner Facility	Required	Not Required	Not Required	Required	Not Required	Not Required
Proximity to Public Transportation	Practitioner Facility	Required	If applicable	Not Required	Required	If applicable	Not required
Business Hours and Days of operations	Practitioner Facility	Required	Required	Required	Required	Required	Required
Web Site URL	Practitioner Facility	If applicable	If applicable	If applicable	If applicable	If applicable	If applicable
Provider's office public email	Practitioner Facility	If applicable	If applicable	If applicable	If applicable	If applicable	If applicable

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Provider Data Elements	Type	Printed/PDF Directory			Web-based Directory		
		Medi-Cal	OneCare	Covered California (Effective: 2027)	Medi-Cal	OneCare	Covered California
address, intended for Member communication							
Facility Physical Accessibility Level (OSHA)	Practitioner Facility	Required	Required	If applicable	Required	Required	If applicable
Program(s)(Covered California-*Effective: 2027*, Medi-Cal and/or Medicare)	Practitioner Facility	Required	Required	Required	Required	Required	Required
Health Network Affiliation	Practitioner Facility	Required	Required	Required	Required	Required	Required
Hospital affiliations and admitting privileges	Practitioner	Required	Required	Required	Required	Required	Required
Hospital quality data	Facility	If applicable	If applicable	Not Required	If applicable	If applicable	Not Required
Hospital accreditation status	Facility	If applicable	If applicable	Not Required	If applicable	If applicable	Not Required
Accepting new Members	Practitioner Facility	Required	Required	Required	Required	Required	Required
Special Services such as California Children's Services Program (CCS)	Practitioner Facility	Required	Required	Not Required	Required	Required	Not Required
Supervising Provider full name and license number for mid-level Providers	Practitioner	If applicable	If applicable	Not Required	If applicable	If applicable	Not Required
Tier	Practitioner Facility	If applicable	If applicable	If applicable	If applicable	If applicable	If applicable

IV. ATTACHMENT(S)

A. CalOptima Health Add/Change/Term (ACT) form
B. ACT Form User Guide

V. REFERENCE(S)

A. California Health and Safety Code (HSC), §§1367.27, and 1367.28
B. CalOptima Health Contract for Health Provider Care Services
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
E. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
F. CalOptima Health Policy DD.2005: Member-Informing Materials Requirements
G. CalOptima Health Policy EE.1101: Additions, Changes, and Terminations to CalOptima Health Provider Information

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H. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Supersedes APL 16-001)
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment (Supersedes APL 19-004) (Revised August 24, 2022)
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule
K. Department of Managed Health Care (DMHC) All Plan Letter (APL) 25-008: Provider Directory Annual Filing Requirements
L. Department of Managed Health Care Uniform Provider Directory Standards
M. Medi-Cal Managed Care Division (MMCD) Policy Letter (PL) 00-002: Supersedes Policy Letter 97-09: Health Plan Provider Directory Policy, Guidelines, and Delivery Standards
N. Medi-Cal Managed Care Division (MMCD) Policy Letter (PL) 11-009: Update to Policy Letter 00-002: Update to Health Plan Provider Directory Policy and Guidelines
O. National Committee of Quality Assurance (NCQA) Health Plan (HP) Standards and Guidelines
P. National Committee of Quality Assurance (NCQA) Health Equity (HE) Standards and Guidelines
Q. Title 42, Code of Federal Regulations (CFR), § 438.10(h)(4), 1367.27(e)(2)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2025	EE.1146	Provider Directory	Covered California Medi-Cal OneCare

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IX. GLOSSARY

Term	Definition
Additions	Term referred to in the Addition, Change, and Termination (ACT) process to add a Provider or Facility to the system of record. Health Networks are recommended to submit ACT forms and necessary documentation as outlined in this policy to add a Provider or Facility pursuant to the terms of the Agreement.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Changes	Term referred to in the Addition, Change, and Termination (ACT) process to make a demographic or other change a Provider or Facility in the system of record. Health Networks are recommended to submit ACT forms and necessary documentation as outlined in this policy to make demographic or other changes to the system of record pursuant to the terms of the Agreement.
Delegated Provider Group	Health care entity with authority to credential its health care Providers.
Facility	For purposes of this policy, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.
Gender-Affirming Services	Includes, but are not limited to, feminizing mammoplasty, male chest reconstruction, mastectomy, gender-confirming facial surgery, hysterectomy, oophorectomy, penectomy, orchiectomy, feminizing genitoplasty, metoidioplasty, phalloplasty, scrotoplasty, voice masculinization or feminization, hormone therapy related to gender dysphoria or intersex conditions, gender-affirming gynecological care, or voice therapy related to gender dysphoria or intersex conditions.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), subcontractor, or first tier entity, that contracts with CalOptima Health to provide covered services to members.
Member	An individual enrolled in a CalOptima Health program.
Primary Care Provider (PCP)	For purposes of this Policy, a person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be and is not limited to a Primary Care Physician or Non-Physician Medical Practitioner. A PCP can be, but is not limited to, a General Practitioner, Internist, Pediatrician, OB/GYN, Indian Health Care Provider (IHCP), Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Nurse practitioner, Physician assistant, or a Clinic.
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services. For purposes of this Policy, any individual, entity, Health Network, or Delegated Provider Group that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.

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Terminations	Term referred to in the Addition, Change, and Termination (ACT) process to terminate a Provider or Facility from the system of record. Health Networks shall submit notification of termination pursuant to the terms of the Agreement.
Threshold Language	Medi-Cal: The non-English threshold and concentration standard languages in which CalOptima Health is required to provide written translations of Member Information, as determined by DHCS. OneCare: A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Kelly Giardina, MSG, CCM, Executive Director, Clinical Operations, (657) 900-1013

Recommended Actions

Approve new CalOptima Health Policy MA. 6045: Special Supplemental Benefits for the Chronically Ill, effective January,1, 2026.

Background

Policy MA. 6045: Special Supplemental Benefits for the Chronically Ill (SSBCI) defines the criteria and process to determine whether a CalOptima Health OneCare member is eligible to receive special supplemental benefits for the chronically ill (SSBCI) when offered by CalOptima Health OneCare.

CalOptima Health offers a supplemental benefit for the chronically ill as outlined in guidelines set forth in Title 42 Code of Federal Regulations (CFR) § 422.102(f). The OneCare Flex Plus program eligibility requires members to have one or more comorbid and medically complex chronic conditions that are life threatening or that significantly limit their overall health or functioning. Eligible conditions include, but are not limited to, cardiovascular disorder, diabetes mellitus, chronic heart failure, chronic lung disease, or end-stage renal disease. Member eligibility is also based on having a high risk of hospitalization or other adverse health outcomes and a need for intensive care coordination.

Discussion

CalOptima establishes new policies and procedures to implement federal and state laws, program regulations, contracts, and business practices. In April 2025, Title 42 CFR § 422.102(f) was amended. The purpose of the new Policy MA.6045 is to describe the process by which CalOptima Health will ensure that decisions related to approval or denial of the requested SSBCI are consistent with the criteria and guidelines set forth in Title 42 CFR § 422.102(f).

Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2024-25 Operating Budget.

Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, staff recommends that the CalOptima Health Board of Directors approve and adopt CalOptima Health Policy MA.6045: Special Supplemental Benefits for the Chronically Ill (SSBCI).

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. New CalOptima Health Policy MA.6045: Special Supplemental Benefits for the Chronically Ill

/s/ Michael Hunn *05/29/2025*
Authorized Signature **Date**

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Policy:	MA.6045
Title:	**Special Supplemental Benefits for the Chronically Ill (SSBCI)**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

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I. PURPOSE

This policy defines the criteria and process to determine whether a CalOptima Health OneCare Member is eligible to receive Special Supplemental Benefits for the Chronically Ill (SSBCI), when offered by CalOptima Health OneCare.

II. POLICY

A. CalOptima Health shall be responsible to ensure that decisions related to approval or denial of the requested SSBCI are consistent with the criteria and guidelines set forth in this Policy and Title 42 Code of Federal Regulation (CFR), Section 422.102(f).

B. When SSBCI is offered by CalOptima Health, eligibility shall be determined using the following criteria:

1. A CalOptima Health OneCare Member requesting SSBCI must meet the definition of Chronically Ill as defined as follows:

a. A Chronically Ill Member has one (1) or more comorbid and medically complex Chronic Health Conditions that meet all of the following:

i. Is life threatening or significantly limits the overall health or function of the Member;

ii. Has a high risk of hospitalization or other adverse health outcomes; and

iii. Requires intensive Care Coordination.

C. CalOptima Health shall document all approvals and denials of SSBCI eligibility determinations and make information and documentation related to determining enrollee eligibility available to CMS upon request.

III. PROCEDURE

A. A Member may request approval of SSBCI through the following methods:

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1. CalOptima Health's OneCare Sales & Marketing department may telephonically screen a Member to determine SSBCI eligibility.

    a. A Member must provide proof of an existing Chronic Health Condition by verifying their prescribed medication list for the chronic condition.

    b. A Member must attest to being admitted to the emergency department or being hospitalized at least once in the previous twelve (12) months.

2. A Member may request their Primary Care Provider or Specialty Care Provider to complete and submit the SSBCI form to CalOptima Health confirming their eligibility for the offered SSBCI.

    a. CalOptima Health's Utilization Management department will receive and review the form.

3. Requests for SSBCI will be processed in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

4. A Member will be notified of approval or denial according to CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

B. The CalOptima Health OneCare Sales & Marketing and Utilization Management departments shall document a Member's SSBCI eligibility status based on the process and criteria outlined in this policy.

IV. ATTACHMENT(S)

A. Special Supplemental Benefits for the Chronically Ill (SSBCI) Form

V. REFERENCE(S)

A. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
B. Title 42 Code of Federal Regulation (CFR), § 422.102(f)

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	TBD	MA.6045	Special Supplemental Benefits for the Chronically Ill (SSBCI)	Medi-Cal

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IX. GLOSSARY

Term	Definition
Care Coordination (or Coordination of Care)	The identification of a medical condition or services that are not covered by OneCare under whose authority CalOptima Health operates. Encompasses services included in Basic Case Management, Complex Case Management, Comprehensive Medical Case Management Services, Person Centered Planning and Discharge Planning and are included as part of a functioning Medical Home. A process used by a person or team to assist Members in accessing Medicare and Medi-Cal Services, as well as social, educational, and other support services, regardless of the funding source for the services. It is characterized by advocacy, communication, and resource management to promote quality, cost effectiveness, and positive outcomes
Chronic Health Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Chronically Ill	A chronically ill member has one (1) or more comorbid and medically complex Chronic Health Conditions that meet all of the following: 1. Is life threatening or significantly limits the overall health or function of the Member; 2. Has a high risk of hospitalization or other adverse health outcomes; and 3. Requires intensive Care Coordination.
Member	A beneficiary enrolled in the CalOptima Health OneCare program.
Primary Care Practitioner/Physician (PCP)/Provider	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.
Special Supplemental Benefits for the Chronically Ill (SSBCI)	A special supplemental benefit for the chronically ill (SSBCI) is a supplemental benefit that has, with respect to a chronically ill enrollee, a reasonable expectation of improving or maintaining the health or overall function of the enrollee; an SSBCI that meets the standard in this paragraph (f)(1)(ii) may also include a benefit that is not primarily health related.

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CalOptima Health OneCare
Flex Plus Grocery Eligibility Form

Please have your provider (doctor, nurse practitioner or physician assistant) fill out this form to find out if you are eligible for the grocery benefit on your Flex Card. You must already be enrolled in CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal. Once this form is filled out and supporting documents submitted by your provider, CalOptima Health will process the request and inform you of your eligibility within 2 weeks.

Step 1: Please fill out all information below and visit your provider (doctor, nurse practitioner or physician assistant) to complete Steps 2 and 3.

Member Information *(please print)*			
Last Name:	First Name:	Date of Birth:	
Mailing Address:		City:	ZIP:
Client Index # (CIN):		Phone #:	

Step 2: Ask your provider (doctor, nurse practitioner or physician assistant) to fill out the form and submit it to CalOptima Health.

Provider to complete all sections below.			
Provider Information *(please print)*			
Last Name:		First Name:	
Address:		City:	ZIP:
NPI #:	TIN:	Phone #:	
Office Contact:		Visit Date:	
Provider Instructions: Check all conditions that apply. Please complete all required checkboxes and attach any supporting documents such as office visit summary, progress notes or medical history for your patient before submission.			

Diagnoses/Conditions: *Patient must have one or more complex chronic condition. Please check all active diagnoses.*
☐ 1. Chronic alcohol and other drug dependence (F1520, F1920)
☐ 2. Autoimmune disorders limited to: ☐ Polyarteritis nodosa (M300) ☐ Polymyalgia rheumatica (M353) ☐ Polymyositis (M3320) ☐ Rheumatoid arthritis (M069) ☐ Systemic lupus erythematosus (M329)

Diagnoses/Conditions: *Patient must have one or more complex chronic condition. Please check all active diagnoses.*
☐ 3. Cancer, excluding pre-cancer conditions or in-situ status (C801, C96Z)
☐ 4. Cardiovascular disorders limited to: ☐ Cardiac arrhythmias (I499) ☐ Coronary artery disease (I259) ☐ Peripheral vascular disease (I739) ☐ Chronic venous thromboembolic disorder (I8291, I82729)
☐ 5. Chronic heart failure (I5022, I5032)
☐ 6. Dementia (F0930)
☐ 7. Diabetes mellitus (E108, E138, E139)
☐ 8. End-stage liver disease (K7210, K7211)
☐ 9. End-stage renal disease (ESRD) requiring dialysis (N186)
☐ 10. Severe hematologic disorders limited to: ☐ Aplastic anemia (D6109) ☐ Hemophilia (D68311) ☐ Immune thrombocytopenic purpura (D693) ☐ Myelodysplatic syndrome (D469) ☐ Sickle-cell disease (excluding sickle-cell trait) (D571, D57819) ☐ Chronic venous thromboembolic disorder (I82509)
☐ 11. HIV/AIDS (B20)
☐ 12. Chronic lung disorders limited to: ☐ Asthma (J45909) ☐ Chronic bronchitis (J42) ☐ Emphysema (J439) ☐ Pulmonary fibrosis (J8410) ☐ Pulmonary hypertension (I2720)
☐ 13. Chronic and disabling mental health conditions limited to: ☐ Bipolar disorders (F319) ☐ Major depressive disorders (F339) ☐ Paranoid disorder (F600) ☐ Schizophrenia (F209) ☐ Schizoaffective disorder (F259)
☐ 14. Neurologic disorders limited to: ☐ Amyotrophic lateral sclerosis (ALS) (G1221) ☐ Epilepsy (G40909) ☐ Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia) (G8190) ☐ Huntington's disease (G10) ☐ Multiple sclerosis (G35) ☐ Parkinson's disease (G20) ☐ Polyneuropathy (G629) ☐ Spinal stenosis (M4800) ☐ Stroke-related neurologic deficit (I6930)

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Diagnoses/Conditions: *Patient must have one or more complex chronic condition. Please check all active diagnoses.*
☐ 15. Stroke (I639)

Risk Level or Care Coordination Needs			
Patient is at high risk for hospitalization or adverse health outcomes.		☐ Yes	☐ No
Hospitalizations in past 12 months?	☐ Yes Dates:		☐ No
ER visits in past 12 months?	☐ Yes Dates:		☐ No

☐ **Patient does not have any of the conditions listed above (not eligible for groceries).**

Provider Signature: _____ Date: _____

Step 3: Provider to send completed eligibility form and supporting documents such as office visit summary, progress notes or medical history to CalOptima Health via:

1. CalOptima Health Provider Portal; OR
2. Fax to (657)-900-1671; OR
3. Mail to P.O. Box 11033, Orange, CA 92856

CalOptima Health OneCare (HMO D-SNP), a Medicare Medi-Cal Plan, is a Medicare Advantage organization with Medicare and Medi-Cal contracts. Enrollment in CalOptima Health OneCare depends on contract renewal. CalOptima Health OneCare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Call CalOptima Health OneCare Customer Service toll-free at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. Visit us at **www.caloptima.org/OneCare**.

The CalOptima Health OneCare Flex Plus grocery benefit is part of a special supplemental program for the chronically ill. Not all members qualify. To use the grocery benefit, CalOptima Health OneCare Flex Plus members must have one or more comorbid and medically complex chronic conditions that are life threatening or significantly limits the overall health or function of the enrollee. Eligible conditions include but are not limited to cardiovascular disorder, diabetes mellitus, chronic heart failure, chronic lung disease, or end-stage renal disease. Even if the member has a chronic condition, the member will not necessarily receive the grocery benefit. Receiving the grocery benefit depends on the member having a high risk of hospitalization or other adverse health outcomes and a need for intensive care coordination.

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Kelly Giardina, MSG, CCM, Executive Director, Clinical Operations, (657) 900-1013

Recommended Actions

Approve new CalOptima Health Policy GG.1669: Complex Cancer Care, effective June 5, 2025.

Background

CalOptima Health Policy GG.1669: Complex Cancer Care provides guidance for coordination of care for the treatment of complex cancers of initial diagnosis, timeliness of intervention, choice of therapy, collaboration among multiple specialty providers, and access to appropriate clinical trials or emerging therapies that may further facilitate the management of a member's care. The policy also provides guidance for CalOptima Health and its contracted Health Network's Annual Network Certification requirements and good faith contracting requirements with certain cancer centers and referral requirements.

CalOptima establishes new policies and procedures to implement federal and state laws, program regulations, contracts, and business practices. In April 2021, DHCS released All-Plan Letter (APL) 23-001: Network Certification Requirements, which superseded APL 21-006. In addition to outlining the Annual Network Certification requirements, APL 23-001 requires managed care plans to make a good faith effort to contract with certain cancer centers or permit members to receive treatment from an out of network cancer center.

Discussion

The purpose of new Policy GG.1669 is to describe the process by which CalOptima Health, delegated Health Networks, and providers coordinate the care for the treatment of complex cancers, including treatment by cancer centers as required by APL 23-001. The policy describes how CalOptima Health and its Health Networks are responsible for providing services for eligible members with a new or existing complex cancer diagnosis.

Fiscal Impact

The recommended action is operational in nature and has no anticipated fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2024-25 Operating Budget.

Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, staff recommends that the CalOptima Health Board of Directors approve CalOptima Health Policy GG.1669: Complex Cancer Care.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. New CalOptima Health Policy GG.1669: Complex Cancer Care

/s/ Michael Hunn *05/29/2025*
Authorized Signature **Date**

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Policy:	GG.1669
Title:	**Complex Cancer Care**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/*
Effective Date:	06/05/2025
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☐ Covered California ☒ Medi-Cal ☒ OneCare ☐ PACE

For 20250605 BOD Review Only

I. PURPOSE

This policy provides guidance for coordination of care for the treatment of complex cancers of initial diagnosis, timeliness of intervention, choice of therapy, collaboration among multiple specialty Providers, and access to appropriate Clinical Trials or emerging therapies that may further facilitate the management of a Member's care. The policy also provides guidance for CalOptima Health and its contracted Health Network's Annual Network Certification (ANC) requirements and good faith contracting requirements with certain cancer centers and referral requirements.

II. POLICY

A. CalOptima Health and its Health Networks are responsible for providing services for eligible Members with a new or existing Complex Cancer Diagnosis, including the identification and referral of Members to a complex cancer care Provider.

B. CalOptima Health and its Health Networks shall use evidence-based guidelines, criteria, or treatment protocols that are medically appropriate given the Member's eligible condition in cases in which clinical guidelines do not exist.

C. CalOptima Health and its contracted Health Networks must make a good faith effort to contract with at least one (1) National Cancer Institute (NCI)-designated comprehensive cancer center, site affiliated with the NCI Community Oncology Research Program (NCORP), or qualifying academic cancer center, as specified within each county in which CalOptima Health operates.

D. CalOptima Health or its Health Networks shall allow eligible Members diagnosed with a Complex Cancer Diagnosis to request a referral to any of the centers in Section II.C. of this policy to receive Medically Necessary services unless the Member chooses a different cancer treatment Provider.

E. CalOptima Health shall conduct its contracting efforts and meet Annual Network Certification (ANC) requirements as outlined in the Department of Health Care Services (DHCS) All Plan Letter (APL) 23-001: Network Certification Requirements and in accordance with CalOptima Health Policy GG.1600: Access and Availability Standards and MA.7007: Access and Availability.

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F. CalOptima Health or its Health Networks shall allow a Member to request services from an Out-of-Network (OON) cancer center if unsuccessful in its good faith contracting efforts or if there is an agreement with respect to payment between CalOptima Health or its Health Network and the OON cancer center.

1. The OON Specialist must be able to provide services to a Member within the applicable time or distance and timely access standards. In the case where the Specialist is not able to provide services under these standards, CalOptima Health or its Health Network shall provide transportation to the appointment.

2. CalOptima Health shall assist the Member in obtaining an appointment with the OON Provider, in person or via Telehealth, at the Member's preference.

G. CalOptima Health and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS APL 23-001: Network Certification Requirements or any superseding DHCS APL and in accordance with CalOptima Health Policy GG.1600: Access and Availability Standards and GG.1665: Telehealth and Other Technology-Enabled Services, MA.2100: Telehealth and Other Technology-Enabled Services, and MA.7007: Access and Availability. Telehealth Providers exclude General Surgery, Orthopedic Surgery, Physical Medicine and Rehabilitation and Hospitals.

1. CalOptima Health and its Health Networks shall not require Members to access services via Telehealth in place of in-person services.

H. Experimental Services are not covered under the DHCS Medi-Cal Program, or Centers for Medicare & Medicaid Services (CMS).

I. Coverage of Investigational Services are covered as specified in CalOptima Health Policy GG.1102: Experimental and Investigational Service Coverage.

J. CalOptima Health and its Health Networks shall cover routine patient care costs associated with a Member's participation in an approved Clinical Trial, in accordance with CalOptima Health Policy GG.1125: Clinical Trials. Clinical Trials supported by National Cancer Institute (NCI) can be found in the NCI Clinical Trials search webpage and ClinicalTrials.gov website.

K. CalOptima Health and its Health Networks shall not require Prior Authorization, nor limit, prohibit, or modify a Member's rights for Biomarker Testing that is associated with an FDA-approved therapy for cancer progression or recurrence in Members with advanced or metastatic stage 3 or 4 cancer or as part of an approved Clinical Trial, in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 22-010: Cancer Biomarker Testing and Health and Safety Code (HSC), §1370.6.

L. Complex Cancer Diagnosis requiring multiple treatment modalities with complex care coordination across multiple specialty Providers shall be refer to the CalOptima Health's Complex Case Management Program for evaluation, in accordance with CalOptima Health Policy GG.1301: Comprehensive Care Management Process.

III. PROCEDURE

A. Referrals for complex cancer care can be received via the Provider Portal, fax, mail or phone and will be processed in accordance with CalOptima Health Policies GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers, and GG.1508: Authorization and Processing of Referrals.

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1. CalOptima Health shall review authorizations and determine if services meet complex cancer care requirements. The clinical review must have sufficient clinical information to make the appropriate Medical Necessity determination.

    a. Coverage determination documentation may include, but is not limited to, the Members' record, documented cancer diagnosis, treatment plan, and credentials of the Provider requesting or performing a medication or service.

2. A denial of a Member's referral request to an NCI or NCORP shall only be denied if:

    a. It is determined that the request to receive services at the NCI or NCOPR is not Medically Necessary;

    b. The services are not available at the requested NCI or NCORP;

    c. Not applicable to the Member's cancer diagnosis; or

    d. OON NCI-designated comprehensive cancer center, NCORP-affiliated site, or qualifying academic cancer center are unable to come to agreement with the respect to payment.

B. A Provider shall obtain Prior Authorization related to a CalOptima Health Member's treatment of complex cancer care in accordance with the policies established by the Member's assigned Health Network.

C. CalOptima Health or its Health Networks shall provide authorized, appropriate Non-Emergency Medical Transportation and Non-Medical Transportation services for complex cancer care in accordance with CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.

D. Authorization requests for OON and Out-of-Area Covered Services requests shall be processed in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

E. At least annually, CalOptima Health shall continually evaluate contracting efforts and outreach attempts, as well as work to improve access in its Provider networks among National Cancer Institute (NCI)-Designated Comprehensive Cancer Center sites affiliated with the NCI Community Oncology Research Program (NCORP) or qualifying academic cancer centers, in accordance with CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts.

F. A Member may Appeal a CalOptima Health or Health Network decision to a requested service in accordance with CalOptima Health Policies GG.1510: Member Appeal Process and MA.9015: Standard Integrated Appeals.

IV. ATTACHMENTS

Not Applicable

V. REFERENCE(S)

A. California Welfare and Institutions Code § 14197.45
B. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
C. CalOptima Health Policy GG.1102: Experimental and Investigational Service Coverage

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D. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers
E. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical
F. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
G. CalOptima Health Policy GG.1510: Member Appeal Process
H. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
I. CalOptima Health Policy GG.1600: Access and Availability Standards
J. CalOptima Health Policy GG.1665: Telehealth and Other Technology-Enabled Services
K. CalOptima Health Policy MA.2100: Telehealth and Other Technology-Enabled Services
L. CalOptima Health Policy MA.7007: Access and Availability
M. CalOptima Health Policy MA.9015: Standard Integrated Appeals
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-001: Network Certification Requirements (Supersedes APL 21-006)
O. Medi-Cal Provider Manual Part 2: Clinical Trials Policy
P. Medi-Cal Provider Manual Part 2: Medicine: Telehealth
Q. Medi-Cal Provider Manual Part 2: Medical Transportation (MTR)
R. Senate Bill (SB) 987 California Cancer Care Equity Act (2021-2022)
S. Title 42 Code of Federal Regulations (C.F.R) § 422.566, §438.400 and §422.561
T. U.S. National Library of Medicine Clinical Trials.gov

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
TBD	Department of Health Care Services (DHCS)	TBD

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/05/2025	GG.1669	Complex Cancer Care	Medi-Cal

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IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a Covered Service, except payment denials based solely because the claim does not meet the definition of a Clean Claim; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
Biomarker Test	A diagnostic test, single or multigene, of an individual's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide treatment. Biomarkers, also called tumor markers, are substances found in higher-than-normal levels in the cancer itself, or in blood, urine, or tissues of some individuals with cancer. Biomarkers can determine the likelihood some types of cancer will spread. They can also help doctors choose the best treatment. For some cancers, certain tumor markers may be more helpful for staging than treatment planning.
Clinical Trial	Trials certified to meet the qualifying criteria and funded by National Institute of Health, Centers for Disease Control and Prevention, Food and Drug Administration (FDA), Department of Veterans Affairs, or other associated centers or cooperative groups funded by these agencies. Criteria for Clinical Trials include the following characteristics: 1. The principal purpose of the Clinical Trial is to test if the intervention potentially improves a participant's health outcomes; 2. The Clinical Trial is well supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use; 3. The Clinical Trial does not unjustifiably duplicate existing studies;

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Term	Definition
	4. The Clinical Trial is designed appropriately to answer the research question being asked in the trial; 5. The Clinical Trial is sponsored by a credible organization or individual capable of successfully executing the proposed Clinical Trial; **6.** The Clinical Trial complies with federal regulations relating to the protection of human subjects; and **7.** All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.
Complex Cancer Diagnosis	A diagnosis for which there is no standard FDA-approved treatment or which known highly effective therapy for metastatic cancer has failed and any of the following diagnoses: hematological malignancies, acute leukemia, advanced, relapsed, refractory non-Hodgkin lymphoma and multiple myeloma, including BPDCN and T-cell leukemias and lymphomas, and advanced stage, relapsed solid tumors refractory to standard FDA-approved treatment options, advanced stage rare solid tumors for which there is no known effective standard treatment options.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	An individual enrolled in a CalOptima Health program

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Term	Definition
National Cancer Institute (NCI)Community Oncology Research Program (NCORP)	A cancer center that has received an approved grant from NCI through NCORP that provides cancer clinical trials and care delivery studies.
Out-of-Area	Outside of the Service Area.
Out-of-Network	Health Network: Outside of the selected Health Network's participating provider network within the Service Area. Provider [CalOptima Health]: A Provider that does not participate in CalOptima Health's Network.
Prior Authorization	Medi-Cal: A formal process requiring a health care Provider to obtain advance approval of Medically Necessary Covered Services, including the amount, duration and scope of services, except in the case of an emergency. OneCare: A process through which a physician or other health care provider is required to obtain advanced approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member
Provider	Medi-Cal: 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. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Telehealth	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.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contact

Kelly Giardina, Executive Director, Clinical Operations, (657) 900-1013

Recommended Actions

Approve new policies and procedures related to Covered California, effective January 1, 2027:

1. CalOptima Health Policy CC.1600: Authorization and Processing of Referrals;
2. CalOptima Health Policy CC.1400: Behavioral Health Services;
3. CalOptima Health Policy CC.1500: Continuity of Care for Members Transitioning into CalOptima Health Services; and
4. CalOptima Health Policy CC.1501: Continuity of Care During Health Network or Provider Termination.

Background

On August 1, 2024, the CalOptima Health Board of Directors (Board) authorized the Chief Executive Officer (CEO) to convene a stakeholder steering committee composed of key external partners and providers to discuss considerations for potential participation in Covered California. CalOptima Health leadership and staff convened the Covered California Stakeholder Steering Committee, which has met on nine separate occasions. On October 3, 2024, the Board directed the CEO to request the Orange County Board of Supervisors (BOS) to amend CalOptima Health's governing ordinance to remove the prohibition on participation in Covered California. On January 14, 2025, the BOS unanimously voted to amend the ordinance to allow CalOptima Health's participation in Covered California. On December 5, 2024, the Board approved actions related to Covered California consulting support contracts and associated funding.

CalOptima Health must obtain approval to operate a Covered California product under its Knox-Keene Act license from the California Department of Managed Health Care (DMHC). Obtaining a Knox-Keene Act license or expanding an existing license is a regulatory filing process that all plans must comply with to offer an individual market health plan. While CalOptima Health is currently licensed with DMHC for the OneCare Medicare product, CalOptima Health must submit a filing to expand its current Knox-Keene Act license to participate in the individual market. As a first step in this process, CalOptima Health participated in a pre-filing conference with DMHC on February 25, 2025.

Discussion

The DMHC filing process is a multi-phased process that CalOptima Health must complete by early 2026 to obtain the proper approvals to operate an individual market health plan. The process requires the

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submission of at least 89 supporting exhibits that demonstrate compliance with the requirements of the Knox-Keene Act.

Several of the documents that must be submitted to DMHC are policies and procedures that demonstrate compliance with statutory and regulatory requirements. Staff has evaluated the policies and procedures that are needed to demonstrate compliance. In the area of clinical operations, staff recommends approval of four new policies and procedures to demonstrate compliance with utilization management and continuity of care standards.

Policies & Procedures Summary - Utilization Management

The DMHC filing requires submission of a description of the Utilization Management Program including:

- Coordinating benefits;
- Criteria for decisions;
- Policies for referrals, denials, authorizations, and second opinions; and
- Concurrent and retrospective review.

These requirements also encompass behavioral health services.

Staff proposes approval of two new policies related to utilization management:

- CC.1600: Authorization and Processing of Referrals.
- CC.1400 Behavioral Health Services.

These new policies demonstrate compliance with DMHC requirements regarding:

- Services not requiring prior authorization (self-referrals);
- Emergency services, including emergency behavioral health services;
- Post-stabilization care;
- Criteria for decisions;
- Policies for referrals, denials, authorizations, and second medical opinions; and
- Prospective, concurrent, and retrospective review.

The policies also include requirements for mental health parity for coverage of behavioral health and substance use disorder services, including processes for triage and referral, utilization review and prior authorization procedures, and out-of-network access. Additionally, both policies outline commercial insurance timeframes and definitions.

To meet the referrals and authorization requirements, staff drafted Policy CC.1600: Authorization and Processing of Referrals to establish coverage and continuity of care guidelines for a member who is involuntarily required to change a health network or provider. Policy CC.1400 Behavioral Health Services includes the scope of all behavioral health services for Covered California.

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These new policies demonstrate compliance with the following statutory requirements and DMHC guidance:

- California Code of Regulations, Title 28 §§ 1300.67, 1300.70, 1300.71.4, 1300.74.72, 1300.74.72.01, 1300.74.72;
- California Health & Safety Code §§ 1262.8, 1317.1, 1363, 1367, 1300.67, 1371, 1374, 1383 1374.72, 1374.721, 1374.724;
- DMHC All Plan Letter (APL) 17-017: Standard for Determining Emergency;
- DMHC APL 21-0002: Implementation of SB 855, MH/SUD Coverage;
- DMHC APL 21-004: Transfer of Unstable or Destabilized Enrollees;
- DMHC APL 23-025: Newly Enacted Statutes Impacting Health Plans;
- DMHC APL 24-007: Implementation of Senate Bill 855 Regulation, Mental Health and Substance Use Disorder Coverage;
- DMHC APL 24-012: Single Point of Contact for Hospitals to Request Authorization for Post stabilization Care;
- DMHC APL 24-021: Notice of Amendments to Rules 1300.67.2.1, 1300.67.2 and Incorporated Documents – Network Adequacy Standards and Methodology for RY 2025; and
- DMHC APL 24-023: Newly Enacted Statutes Impacting Health Plans (2024 Legislative Session).

Staff seeks Board approval of the attached new policies, effective January 1, 2027.

Policies & Procedures Summary – Continuity of Care

The DMHC filing requires submission of policies and procedures covering the continuity, timeliness, and coordination of care between and among providers.

Staff drafted two new policies to demonstrate compliance with these requirements:

- CC.1500: Continuity of Care for Members Transitioning into CalOptima Health Services.
- CC.1501: Continuity of Care During Health Network or Provider Termination.

Statutory and regulatory requirements mandate that CalOptima Health comply with requirements for providing continuity of care when a member is involuntarily required to change providers due to a termination of CalOptima Health's contract with a health network or provider or when a member newly transitions into the CalOptima Health plan. In addition, CalOptima Health must meet specific requirements for high-risk members when another Covered California plan leaves the market and members are transitioned to CalOptima Health.

To meet the continuity of care requirements, staff drafted Policy CC.1500: Continuity of Care for Members Transitioning into CalOptima Health Services to establish coordination of care among providers; timely communication of clinical information among providers; transitions of care; and co-payments, deductibles, or other cost sharing requirements for services with a nonparticipating provider.

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In addition, Policy CC.1501: Continuity of Care During Health Network or Provider Termination establishes coverage and continuity of care guidelines for a member who is involuntarily required to change a health network or provider.

These new policies demonstrate compliance with the following statutory and regulatory requirements:

- California Code of Regulations, Title 28 §§ 1300.67.1(c) through (e), 1300.80(b)(4);
- California Health & Safety Code §§ 1367(d), 1373.95, 1373.96, 1374.73; AND
- Qualified Health Plan Contract (QHP) for Covered California.

Staff seeks Board approval of the attached new policies, effective January 1, 2027.

Fiscal Impact
The recommended action is operational in nature. The anticipated costs will be included in future Covered California operating budgets.

Rationale for Recommendation
Approval of the four new policies and procedures related to clinical operations will support CalOptima Health's application to expand its Knox-Keene Act license to operate an individual market plan.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Attachment 1: CalOptima Health Policy CC.1600: Authorization and Processing of Referrals
2. Attachment 2: CalOptima Health Policy CC.1400: Behavioral Health Services
3. Attachment 3: CalOptima Health Policy CC.1500: Continuity of Care for Members Transitioning into CalOptima Health Services
4. Attachment 4: CC.1501: Continuity of Care During Health Network or Provider Termination

/s/ Michael Hunn *05/29/2025*
Authorized Signature **Date**

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Policy:	CC.1600
Title:	**Authorization and Processing of Referrals**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/*
Effective Date:	01/01/2027
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☒ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250605 BOD Review Only

I. PURPOSE

This policy outlines the process for CalOptima Health and its Health Networks to receive, review, authorize, and process Referrals to physicians or other health professionals, including the procedures for documenting and following up on Referrals in accordance with specified timeframes.

II. POLICY

A. CalOptima Health and its Health Networks shall authorize and process requests for Referrals to physicians or other health professionals using Prior Authorization, including prospective review, Concurrent Review, and Retrospective Review within the timeframes specified in this policy. CalOptima Health and its Health Networks shall maintain appropriate communication with the Member, the Member's Authorized Representative, and Provider throughout the Prior Authorization process to facilitate delivery of appropriate services.

B. CalOptima Health and its Health Networks shall follow the applicable timeframes in Attachment A: Timeframes for Covered California Decisions and Notifications Table (Attachment A) to this policy, for all requested services, whether in-network or Out-of-Network, as well as CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

C. CalOptima Health and its Health Networks shall ensure that clinical decision made related to coverage or denial of requested services due in whole or in part to Medical Necessity are consistent and based upon sound medical evidence, in accordance with CalOptima Health Policies GG.1535: Utilization Review Criteria and Guidelines, and GG.1541: Utilization Management Delegation.

D. CalOptima Health and its Health Networks shall ensure the Authorization process for Covered Services is consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.

E. CalOptima Health and its Health Networks will notify network Providers of all services that require authorization, including Prior Authorization, concurrent Authorization, or retrospective Authorization.

F. CalOptima Health and the Health Networks shall make utilization management (UM) decisions based only on appropriateness of care and service, and existence of coverage. CalOptima Health and the Health Networks do not reward Providers or other individuals for issuing denial for coverage, care, or

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services. CalOptima Health and the Health Networks do not provide financial incentives to UM decision-makers to encourage decisions that result in underutilization.

G. CalOptima Health and the Health Networks shall not require a Provider to request Prior Authorization for Covered Services specified in Section III.A. of this policy.

H. For services that do not require a Prior Authorization, Providers, including Specialist Physicians, shall refer the Member to a Contracted Provider, unless such Provider is unavailable. The geographic access standards set forth minimum standards of accessibility for network adequacy as detailed in CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access. Referrals to a Non-Contracted Provider shall be processed in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

I. CalOptima Health and its Health Networks shall ensure that all Contracted Providers and Non-Contracted Providers, including non-contracting Specialist Physicians, are informed of the Prior Authorization and Referral process at the time of Referral.

J. CalOptima Health and its Health Networks that are responsible for UM of hospital services shall have a medical director or other licensed physician available twenty-four (24) hours a day, seven (7) days a week to authorize Medically Necessary Post-Stabilization Care, to coordinate the transfer of Stabilized Members in an emergency department, if necessary, and for general communication with emergency room personnel.

K. CalOptima Health and its Health Networks provide coverage and payment for hospital Emergency Services and Care and Post-Stabilization Care as necessary to determine the presence or absence of an Emergency Medical Condition, including a Psychiatric Emergency Medical Condition. If an Emergency Medical Condition exists, this shall include all services Medically Necessary to Stabilize the Member's condition regardless of whether or not the request is from a Contracted Provider, Non-Contracted Provider, or Out-of- Network Provider.

L. CalOptima Health and its Health Networks shall each maintain a system for tracking and monitoring all Referrals for Provider and Member-requested health care services and supplies requiring Prior Authorization as follows:

1. Referral turnaround time for issuing a determination;

2. Criteria used in making the determination;

3. If denied, delayed, or modified, a copy of the denial, delay, or modification notice; and,

4. Specific services and supplies approved, denied, delayed, or modified, including classifying non-Medical Necessity denials.

M. CalOptima Health shall regularly monitor and oversee its delegates and subcontractors and ensure that its delegates and subcontractors comply with all applicable requirements of this policy, the Knox-Keene Act, and CalOptima Health policies, including CalOptima Health Policy GG.1541: Utilization Management Delegation and CalOptima Health Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Self-Referrals or Services Excluded from the Prior Authorization Process

1. Members may self-refer to the following services without Prior Authorization (if CalOptima Health or a Health Network receives a request for these self-referral services, CalOptima Health shall notify the Member and the Provider that a Referral is not required):

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a. Emergency Services and Care, including Behavioral Health Care, shall be available and accessible to Members twenty-four (24) hours a day, seven (7) days a week within CalOptima Health's service area. This shall include ambulance services for the area served by CalOptima Health to transport the Member to the nearest twenty-four (24)-hour emergency facility with physician coverage, as designated by CalOptima Health. CalOptima Health and its Health Networks shall ensure the following:

i. CalOptima Health and its Health Networks shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

ii. CalOptima Health and its Health Networks shall reimburse Providers for Emergency Services and Care provided to Members until the care results in Stabilization of the Member, except under the following circumstances:

a) CalOptima Health or its Health Networks reasonably determine that the Emergency Services and Care were never performed.

b) CalOptima Health or its Health Networks may deny reimbursement to a Provider for a medical screening in cases when the Member did not require Emergency Services and Care and the Member reasonably should have known that an emergency did not exist.

iii. A Provider is not required to seek Prior Authorization to provide Emergency Services and Care or to make a transfer for a Member who has a Psychiatric Emergency Medical Condition that is not otherwise required by law.

iv. Notwithstanding Title 28 of the California Code of Regulations (CCR) § 1300.71.4(b)(1) and (2), CalOptima Health shall pay for all Medically Necessary health care services provided to a Member that are necessary to maintain the Member's Stabilized condition up to the time that CalOptima Health effectuates the Member's transfer or the Member is discharged.

v. The attending emergency physician, or the Provider otherwise treating the Member within the scope of that Provider's licensure, is responsible for determining when the Member is sufficiently Stabilized for transfer or discharge, and that determination is binding CalOptima Health and Health Networks.

b. Urgent care.

c. Crisis stabilization, including Behavioral Health Crisis Services.

d. Family planning services.

e. Basic prenatal care.

f. Routine and preventive gynecological care.

g. Communicable disease services, including sexually transmitted infections and human immunodeficiency virus testing and counseling.

h. Sexual assault services.

i. Reproductive and sexual health care services.

j. Sensitive services for minors, age twelve (12) years and older.

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k. Preventive services.

l. Tobacco cessation services.

m. COVID-19 diagnostic testing.

B. Referral Responsibilities of Primary Care Physician (PCP)

1. A PCP shall be responsible for providing initial and primary care to Members, for maintaining the continuity of patient care, or for initiating a Referral for specialist care. A PCP may be either a physician who has limited the practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family Practitioner.

a. Covered California Members may also select nurse practitioners and physician assistants to serve as their primary care clinician.

2. PCPs shall be responsible for coordinating Medically Necessary services for Members, including initiating Referrals for, but not limited to, specialty services, second opinions, outpatient services, ancillary services, or to other health professionals or services and resources required to meet a Member's health care needs. CalOptima Health or its Health Networks shall provide consultation with and Referral by physicians to other physicians when Medically Necessary, including to other health professionals as specified in Title 28 CCR § 1300.67(a)(1).

3. When possible, the PCP shall evaluate and counsel the Member and direct the Member to the most appropriate level of service based on the Member's condition, as detailed in CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities.

C. Member Eligibility Verification

1. A Provider shall request basic information from a Member when providing services, including access to the Member's Covered California identification card, or shall perform an eligibility verification using CalOptima Health's Provider Portal at www.caloptima.org.

2. Prior Authorization does not guarantee eligibility at the time services are rendered.

D. Submission of Referral or Authorization Requests

1. A Provider shall request the following Authorizations:

a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.

b. Request for Concurrent Review for services needing Authorization, but which have begun without Prior Authorization in place, and are continuing.

c. Request for Retrospective Review, subject to the limitations described in Section III.F.2. of this policy.

2. A Provider shall submit a completed Authorization Request Form (ARF), including physician signature or written physician order, as well as current medical documentation supporting the need for the requested services to the CalOptima Health UM Department.

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3. A Contracted Provider may submit a routine, non-urgent Authorization request online via the CalOptima Health Provider Portal. The Contracted Provider must upload medical documentation to the CalOptima Health Provider Portal to support the Medical Necessity of the requested services.

4. For Urgent Authorization Requests, the Provider must:

    a. Specify that the request is urgent on the ARF and fax along with medical documentation; or

    b. Notify the CalOptima Health UM Department of the urgent request by telephone.

5. An Urgent Authorization Request may be submitted if a routine Authorization timeframe will be detrimental to a Member's life or health, jeopardize the Member's ability to regain maximum function, or may result in loss of life, limb, or other major body function. A decision on an Urgent Authorization Request must be made within seventy-two (72) hours or as soon as the Member's health condition requires.

6. A hospital must submit the request for Prior Authorization and obtain approval from CalOptima Health or a Health Network, as applicable, prior to a Member's admission to inpatient status.

7. All CalOptima Health and Health Network Authorization requests must include clinical records that validate the need for the requested item or service.

8. Hospital Notification of Emergency Services and Care

    a. A hospital shall notify CalOptima Health or the Member's Health Network, as applicable, within twenty-four (24) hours of a Member's Initial Emergency Encounter. Until a notification system is implemented, a hospital shall use best efforts to provide such notice within twenty-four (24) hours of the Member's presentation to the emergency department for outpatient Emergency Services and Care.

    b. If the Initial Emergency Encounter occurs on a holiday or weekend, notification to CalOptima Health or the Member's Health Network shall be made the following business day, or at the time Member's identity is known, or would have been known with the exercise of reasonable diligence.

9. Medically Necessary Post-Stabilization Care from Contracted Providers and Non-Contracted Providers

    a. A hospital must submit a Prior Authorization request for Post-Stabilization Care when a Member who has received Emergency Services and Care for an Emergency Medical Condition, including a Psychiatric Emergency Medical Condition, is determined to have reached medical stability, but requires additional, Medically Necessary inpatient Covered Services that are:

        i. Related to the Emergency Medical Condition; and

        ii. Provided to maintain, improve, or resolve the Member's Stabilized medical condition.

    b. A hospital shall submit a request for Medically Necessary Post-Stabilization Care through CalOptima Health's twenty-four (24) hour access telephone line.

        i. CalOptima Health or its Health Networks shall also provide twenty-four (24) hour access for Members and Providers, including Non-Contracted Provider hospitals, to obtain

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timely authorization for Medically Necessary Post-Stabilization Care for circumstances where the Member has received Emergency Services and Care, but the treating Provider believes that the Member may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorization.

ii. CalOptima Health or its Health Networks shall not require a hospital to make more than one telephone call to request approval for Medically Necessary Post-Stabilization Care, provided that CalOptima Health or its Health Network is able to reach a representative of the hospital upon returning the call, should a call back be necessary.

iii. CalOptima Health shall provide the DMHC and all Non-Contracted Provider hospitals in California with specified contact information needed to submit requests for Medically Necessary Post-Stabilization Care, which shall be updated as necessary but no less than annually.

c. All requests and responses to a Post-Stabilization Care request are required to be fully documented. Documentation shall include but is not limited to;

i. The date and time of the request;

ii. The name of the health care Provider making the request; and

iii. The name of the CalOptima Health or Health Network staff responding to the request.

d. A Prior Authorization request for Medically Necessary Post-Stabilization Care shall consist of an initial telephone call to CalOptima Health's twenty-four (24) access telephone line, provided that in all cases, CalOptima Health or its Health Networks shall be able to reach a hospital representative upon returning the call should that be necessary.

e. Upon request by CalOptima Health or its Health Networks, the hospital shall provide the treating physician and surgeon's diagnosis and any other relevant information reasonably necessary for CalOptima Health or a Health Network's UM Department clinician to make a decision regarding care within thirty (30) minutes. The hospital shall provide, at a minimum, the following information:

i. Identifying information, including Member name, birthdate, Member identification number, and gender;

ii. Name and role of facility clinician requesting Prior Authorization, their direct phone number, and the name of the facility;

iii. Nature of the Emergency Medical Condition that has been Stabilized;

iv. Medical documentation to include at a minimum:

a) History and physical;

b) Vital signs; and
c) Laboratory and/or radiology results.

v. Co-morbid conditions; and

vi. Medical reason for admission to the hospital, including proposed treatment.

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f. CalOptima Health or the Health Network shall approve or deny a Prior Authorization request for Post-Stabilization Care within thirty (30) minutes of the time the hospital makes the initial telephone call making the request, and after receipt of a request that fully complies with Section III.E.1.a-c of this policy. If CalOptima Health or the Health Network fails to approve or deny such request within thirty (30) minutes, Medically Necessary Post-Stabilization Care services are deemed approved.

i Notwithstanding Section III.J.5. of this policy and in accordance with 28 CCR § 1300.71.4, CalOptima Health or the Health Network may notify the Provider of the denial of such request prior to the commencement of the delivery or during the continuation of the delivery of Post-Stabilization Care, provided that the disruption of such services (taking into account the time necessary to effect the Member's transfer or discharge) does not have an adverse impact on the efficacy of such services or the Member's medical condition.

ii In the case where CalOptima Health or the Health Network denies such request and informs the Provider of its decision to transfer the Member to another Provider, CalOptima Health or the Health Network, as applicable, shall effectuate the transfer of the Member as soon as possible.

g. CalOptima Health and its Health Networks are also financially responsible for Post-Stabilization Care in the event that CalOptima Health or the Health Network:

i. Could not be contacted;

ii. Did not respond to a request for Prior Authorization for Post-Stabilization Care within the timeframe allotted of thirty (30) minutes;

iii. Authorizes the hospital to provide Medically Necessary Post-Stabilization Care;

iv. Notified the Non-Contracted Provider hospital that it would assume management of the Member's care by prompt transfer, but CalOptima Health or its Health Network failed to transfer the Member within a reasonable time;

v. There is an unreasonable delay in the transfer of the Member, and the Non-Contracted Provider physician and surgeon determines that the Member requires Post-Stabilization Care; or,

vi. Could not reach an agreement with the treating Provider concerning the Member's care and CalOptima Health or the Health Network physician was not available for consultation.

h. In the case where CalOptima Health or a Health Network and the treating Provider cannot reach an agreement concerning the Member's care and the CalOptima Health or Health Network physician is not available for consultation, CalOptima Health or the Health Network shall give the treating Provider the opportunity to consult with a CalOptima Health or Health Network physician and the treating Provider may continue with care of the Member until a CalOptima Health or the Health Network physician is reached or one (1) of the following criteria is met:

i. CalOptima or the Health Network physician with privileges at the treating Provider's hospital assumes responsibility for the Member's care;

ii. CalOptima Health or the Health Network physician assumes responsibility for the Member's care through transfer;

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iii. CalOptima Health or the Health Network and the treating Provider reach an agreement concerning the Member's care; or

iv. The Member is discharged.

10. Medically Necessary Non-Urgent Care Following Emergency Room Exam

a. CalOptima Health shall process a Prior Authorization request from a Non-Contracted Provider for Medically Necessary non-urgent care following an exam in the emergency room.

b. For a Health Network Member, a Health Network shall approve or deny a Prior Authorization request for non-urgent care following an exam in the emergency room within thirty (30) minutes after receipt of such request from a non-contracted Provider on behalf of a Member who has received Emergency Services and Care. If the Health Network does not respond to such request within the required timeframe, Medically Necessary non-urgent care is deemed approved.

c. Health Network staff shall assist the hospital with timely Discharge Planning to facilitate transition to the most appropriate level of care following facility discharge in accordance with the Health Network's policy.

11. Mental Health and Substance Use Disorder Triage and Referral

a. CalOptima Health maintains a telephone intake system for Members, which is staffed by trained and individually licensed mental health professionals, or supervised by a licensed mental health professional, and which provide for appropriate crisis intervention and initial Referrals to mental health Providers in accordance with CalOptima Health Policies CC.1700: Standards of Accessibility and Timely Access and CC.1400: Behavioral Health Services.

E. Referral Review Process

1. Once a Referral to a physician or other health care Provider is submitted through the CalOptima Health Provider Portal, or by mail, telephone or fax, the Referral will be assigned a tracking number and will undergo auto-adjudication review.

2. The CalOptima Health Provider Portal functionality includes Referral intelligence rules, approved by clinical leadership to auto-approve when criteria are met. The Referral intelligence rules and auto-approval trends are reviewed quarterly at a minimum to identify potential misuse or utilization issues that require follow up. If auto-approval criteria is met, the Referral will be automatically approved by CalOptima Health and its Health Networks.

a. To the extent that CalOptima Health and its Health Networks use, or contract with an entity that uses, Artificial Intelligence, an algorithm, or other software tool (AI Tool) for the purpose of UM review or functions, a determination by an AI Tool shall be based on the following information, as applicable and in accordance with Health and Safety Code § 1367.01(k):

i. A Member's medical or other clinical history;
ii. Individual clinical circumstances as presented by the requesting Provider;

iii. Other relevant clinical information contained in the Member's medical or other clinical record.

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3. All Referral Authorizations that do not meet the auto-approval criteria will undergo further UM review. CalOptima Health and its Health Networks will make Medical Necessity reviews consistent with criteria or guidelines that are supported by clinical principles and processes, in accordance with CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines.

F. Referral System Turnaround Times

1. CalOptima Health will track, compile, and evaluate authorized, denied, delayed, or modified Referrals and the timeliness of the Referrals, in compliance with state law and regulatory guidelines and as set forth in Attachment A.

2. Referrals will be processed consistently using the following timeframes:

a. Prospective and Concurrent Review:

i. Urgent: Within seventy-two (72) hours from receipt of the information reasonably necessary to render a decision, unless a CalOptima Health or Health Network contract requires a shorter timeframe.

ii. Routine: Within five (5) business days from receipt of the information reasonably necessary to render a decision, unless a CalOptima Health or Health Network contract requires a shorter timeframe.

b. Retrospective Review.

i. Within thirty (30) calendar days from receipt of information that is reasonably necessary to make the determination.

c. Post-Stabilization Care.

i. Within thirty (30) minutes of the request. CalOptima Health or the Health Network shall approve or deny a Provider's Prior Authorization request for Post-Stabilization Care within thirty (30) minutes after receipt of request that fully complies with Section III.D.7 of this policy. If CalOptima Health or the Health Network fails to approve or deny such request within thirty (30) minutes, Medically Necessary Post-Stabilization Care services are deemed approved.

d. All Referrals are subject to the Member's eligibility and, if approved, Providers will be granted one hundred eighty (180) days to render services.

e. Referral requests for Mental Health and Substance Use Disorder services shall follow specified timeframes for urgent and non-urgent care in accordance with CalOptima Health Policy CC.1400: Behavioral Health Services.

G. Extending Referral Requests

1. If CalOptima Health requires additional information from a Provider to make a decision to approve, modify, or deny a Referral within the appropriate timeframes, CalOptima Health will notify the Member and the Provider possessing the additional information required.

2. If CalOptima Health or its Health Networks requests information from a Provider in order to determine whether to approve, modify, or deny requests, CalOptima Health or its Health Network shall request only the information reasonably necessary to make the determination and no longer than fourteen (14) calendar days from receipt of the request.

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3. CalOptima Health will identify the type of additional information needed, the timeframe for submitting the additional information, the anticipated date of decision, the physician reviewer's name and direct phone number, and the Member's grievance rights.

H. Second Medical Opinions

1. A Member, or the Member's Authorized Representative or Provider who is treating the Member, has the right to request a second opinion by an appropriately qualified health care professional who is a PCP or Specialist Physician acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request.

2. CalOptima Health or its Health Networks shall provide or authorize a Referral for a second opinion for any of the following reasons:

   a. If the Member questions the reasonableness or necessity of recommended surgical procedures.

   b. If the Member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to a serious chronic condition.

   c. If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the Member requests an additional diagnosis.

   d. If the treatment plan in progress is not improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment.

   e. If the Member has attempted to follow the plan of care or consulted with the initial Provider concerning serious concerns about the diagnosis or plan of care.

3. A Member or the Member's Authorized Representative may request a second opinion from their Practitioner or by contacting CalOptima Health's Customer Service Department or the Member's Health Network.

4. If the Member faces an imminent and serious threat to his or her health, or the lack of timeliness would be detrimental to the Member's ability to regain maximum function, CalOptima Health and its Health Networks shall authorize or deny second opinion requests within seventy-two (72) hours. All other second opinion requests deemed non-urgent will be authorized or denied in an expeditious manner.

5. CalOptima Health or a Health Network requires Prior Authorization for a second opinion by a Specialist Physician.

6. A Member who requests a second opinion may be allowed to choose from any Provider within CalOptima Health or its Health Network and who is of the same or equivalent specialty to provide the second opinion. A Member may receive a second opinion from a Contracted Provider at no cost other than applicable copayments required for similar Referrals.

7. If a Contracted Provider is not available, CalOptima Health or its Health Network shall make arrangements for the Member to obtain a second opinion from an Out-of-Network Provider. In

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approving a second opinion either inside or outside of the network, CalOptima Health shall take into account the ability of the Member to travel to the Provider.

8. If a Member requests a second opinion from an Out-of-Network Specialist Physician, CalOptima Health and its Health Network shall incur the cost or negotiate the fee arrangement for the second opinion, beyond the applicable copayments for the Member.

9. If CalOptima Health or its Health Networks denies the request for a second opinion, the Member will be notified in writing of the reasons for the denial, the Member's right to file a grievance, including a written denial notice that complies with Health & Safety Code § 1368.02(b) and as detailed in CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

I. Out-of-Network Services

1. CalOptima Health or a Health Network shall provide Medically Necessary and Covered Services, including Mental Health and Substance Use Disorder services, to a Member through an Out-of-Network Provider when CalOptima Health or the Health Network is unable to provide services within the network, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services. When a Member is required to travel beyond certain geographic access standards as detailed in CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access, that service is presumed to be unavailable in-network.

2. If such Mental Health and Substance Use Disorder services are not available to a Member in accordance with geographic and timely access standards as specified in CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access, CalOptima Health shall provide and arrange coverage for Medically Necessary Mental Health and Substance Use Disorder services from an Out-of-Network Provider(s), as detailed in CalOptima Health Policy CC.1400: Behavioral Health Services.

3. All Referral requests requiring Prior Authorization shall require the requestor to submit a fully completed ARF to CalOptima Health along with medical justification sufficient to make a determination and the physician signature. CalOptima Health shall process the request within the applicable timeframe specified in Attachment A.

4. CalOptima Health or a Health Network shall follow Attachment A for all requested services, whether in or out of the network.

5. CalOptima Health or a Health Network shall arrange for a Letter of Agreement (LOA) with an identified Out-of-Network Provider, in accordance with CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts.

6. CalOptima Health or a Health Network shall provide continued access as follows:

   a. For existing and newly enrolled Members, Continuity of Care to complete covered services by a terminated Contracted Provider or by Non-Contracted Providers from whom the Members was receiving services prior to enrolling with CalOptima Health may be requested. Continuity of Care will be available to Members if the Member was receiving services from the terminated Contracted Providers or Non-Contracted Providers, as applicable, for any of the services as specified in CalOptima Health Policy CC.1501: Continuity of Care During Health Network or Provider Termination.

J. Denials, Delays, Dismissals, Terminations, and Modifications of Prior Authorization Requests

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1. In-Network Specialist Physician. CalOptima Health or a Health Network may redirect specialty care Prior Authorization requests to an in-network Specialist Physician under the following conditions:

    a. All modification, denial, dismissal, termination and notification requirements are followed pursuant to CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization; and

    b. The in-network Specialist Physician is selected based on the following:

        i. A demonstrated ability to provide the services requested;

        ii. Prolific experience providing the services requested;

        iii. Volume of the requested care previously provided;

        iv. An existing relationship with CalOptima Health or the Health Network, as applicable;

        v. A proven ability to maintain adequate Member access;

        vi. A proven ability to provide care coordination; and

        vii. No existing issues related to Continuity of Care or tertiary service needs.

2. Consultation with Board-Certified Specialist

    a. CalOptima Health may consult with a Board-Certified specialist if the Prior Authorization request is out of the scope of practice of the physician reviewer.

        i. A CalOptima Health Medical Director shall forward a request for review by a Board-Certified specialist to the Prior Authorization manager or Designee for appropriateness;

        ii. The Prior Authorization manager or Designee shall forward the request to a contracted external review agency electronically for review; and

        iii. Upon receipt of the recommendation of the external review agency, the CalOptima Health Medical Director shall conduct the final review and determination.

    b. The Utilization Management Committee (UMC) shall maintain a list of Board-Certified specialists and will be reviewed annually by the Quality Improvement Committee.

3. Tertiary Care

    a. CalOptima Health or a Health Network shall authorize Tertiary Care services when a Member requires testing or treatment that is otherwise not available at a non-tertiary level of care.

    b. CalOptima Health shall only authorize Tertiary Care services under the following circumstances:

        i. A Member requires testing or treatment that is otherwise not available at a non-tertiary level of care;

        ii. A Member requires interdisciplinary or simultaneous treatments with multiple specialty services as part of a complex, coordinated plan of care;

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iii. A Member requires testing or treatment that is otherwise too high of a risk or otherwise not safe to perform at a non-tertiary level of care;

iv. A Member or Provider requires a referral for experimental or investigational procedures not available in-network and may do so directly through CalOptima Health; and

v. There is no quality-of-care issues for the Provider.

4. Utilization Management (UM) Decision. CalOptima Health and its Health Networks shall ensure the following:

a. Requested health care services may be approved by UM staff who are not qualified health care professionals only when:

i. The UM staff is under the supervision of an appropriately licensed Provider;

ii. There are explicit UM criteria; and

iii. No clinical judgement is required.

b. Requested health care services that require the use of clinical judgement shall be approved by Providers who are competent to evaluate clinical issues related to the requested services.

c. Decisions to deny or to modify an amount, duration, or scope less than the requested health care services shall be made by a qualified medical director with a current and unrestricted license to practice in California or other licensed health care professional with appropriate clinical expertise in treating the condition and disease.

i. Only a qualified, licensed physician or other qualified, licensed health care professional, as appropriate, shall deny or modify an amount, duration, or scope less than the requested health care services based in whole or in part on Medical Necessity for any non-behavioral healthcare services.

ii. Only a qualified, licensed physician, psychiatrist, or licensed behavioral healthcare professional, as appropriate, shall review and issue denials or modify Mental Health and Substance Use Disorder services for Medical Necessity or benefit coverage related to a Member's Mental Health and Substance Use Disorder benefits; and

iii. Only a qualified, licensed physician or qualified, licensed clinical pharmacist shall review and approve, defer, modify or deny prior authorizations for pharmaceutical services.

d. Only qualified, licensed health care professionals supervise review decisions requiring Referral requests, and a qualified, licensed physician shall review all denials of a request for health care services based in whole or in part on Medical Necessity.

i. CalOptima Health and/or its Health Networks review the authorization universe reporting on an ongoing basis to monitor name and title of individuals making Medical Necessity decisions to modify or deny requested services.

5. Notification of UM Decision: CalOptima Health and its Health Networks shall notify the requesting Provider and the Member or Member's Authorized Representative, as appropriate, regarding any decision to approve, deny, delay, or modify a Referral request in accordance with

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CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. This shall include the following:

a. Communications regarding decisions to approve requests for Referrals shall specify the specific health care services that have been approved.

b. Communications regarding decisions to deny, delay, or modify requests for Referrals shall include the following:

i. Clear and concise explanation of the reasons that CalOptima Health or the Health Network used to base its decision upon.

ii. Description of the criteria or guidelines used.

iii. Clinical reasons for the decisions based on Medical Necessity.

c. CalOptima Health and its Health Networks shall notify the requesting Provider of its decision to approve, deny, delay, or modify health care services initially by telephone, facsimile or electronically and then in writing within twenty-four (24) hours of making the decision.

d. CalOptima Health and its Health Networks shall include the name and direct telephone number or an extension of the health care professional responsible for the denial, delay, or modification decision.

e. CalOptima Health and its Health Networks shall notify the Member and/or the Member's Authorized Representative of decisions to approve, deny, delay, or modify health care services in writing within two (2) business days.

f. Communications regarding decisions to deny, delay, or modify Mental Health and Substance Use Disorder services shall follow notification requirements and timeframes in accordance with CalOptima Health Policy CC.1400: Behavioral Health Services.

J. Availability of CalOptima Health UM Staff and Services

1. CalOptima Health's UM Department shall provide Members or potential Members access to information about the UM process, and the process for authorizing care, in the Covered California Member Handbook/Evidence of Coverage), available in-print and on the CalOptima Health website at www.caloptima.org.

2. CalOptima Health's UM Department shall provide Providers access to information about the UM process, and the process for authorizing care, in the Provider Manual, available on the CalOptima Health website at www.caloptima.org.

3. UM staff shall be available for inbound calls, including toll free and collect calls, regarding UM issues during CalOptima Health normal business hours, Monday – Friday, from 8 a.m. to 5 p.m., with the exception of holidays. All inbound calls will be received by CalOptima Health's Customer Service Department and routed to appropriate UM staff.

a. UM staff shall provide a toll-free number and accept collect calls regarding UM issues.

b. UM staff shall identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues.

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c. UM staff shall send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.

d. UM staff shall be accessible to callers who have questions about the UM process.

e. UM qualified, licensed physicians shall be available to answer denial determination questions during normal business hours and after hours calls regarding UM issues. During business hours, calls shall be directed to the UM Department and transferred to the appropriate UM physician. The after-hours answering service shall direct calls to the on-call physician.

f. A UM physician shall respond to a treating Provider request within thirty (30) minutes for an emergency call and within one (1) business day for all other requests.

4. UM staff shall be available to receive inbound communication regarding UM issues after normal business hours through the on-call-service, facsimile, electronic, and telephone communications (e.g., sending e-mail messages or leaving voicemail messages). CalOptima Health has Medical Director and UM coverage twenty-four (24) hours a day, seven (7) days a week through after-hours on-call and answering services.

   a. Communications received after normal business hours are returned on the next business day.

   b. Communications received after midnight on Monday-Friday are responded to on the same business day.

5. CalOptima Health shall utilize a telecommunications device for the deaf/telephone typewriter, or teletypewriter (TDD/TTY) services for deaf, hard of hearing or speech impaired, or comparable device or service available to assist Members, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic and Services (CalOptima Health is able to receive and send TDD/TYY messages and has a separate phone number for receiving TDD/TYY messages.).

6. CalOptima Health shall provide language assistance services free of charge to Members. CalOptima Health shall provide services in the requested language through bilingual staff or an interpreter, to assist Members with UM issues, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

7. CalOptima Health shall send a CalOptima Health Covered California Member Handbook/Evidence of Coverage (EOC) booklet as part of the enrollment packet, as specified in CalOptima Health Policy DD.2005: Member-Informing Materials Requirements. The handbook will note the availability of UM staff in regard to UM issues and will include the Customer Service Department phone number and the TDD/TTY phone number.

8. Annually, CalOptima Health shall inform Members of the availability of the CalOptima Health Member Handbook/Evidence of Coverage.

K. Failure of a Health Network or CalOptima Health department to comply with CalOptima Health's Authorization policies and procedures, as applicable, as well as relevant statutory, regulatory, and/or contractual requirements, shall lead to disciplinary action, which may include, but not be limited to, education and training on CalOptima Health's Authorization process and reports to the UMC, Delegation Oversight Committee, and/or the Compliance Committee.

1. Continued non-compliance may lead to issuance of corrective action and/or sanctions, in accordance with CalOptima Health Policies HH.2002: Sanctions and HH.2005: Corrective Action Plan.

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L. CalOptima Health and its Health Networks shall establish a process to monitor the appropriate utilization of medical care and services delivered to Members and ensure that care is monitored, analyzed, and interventions are implemented upon the identification of under and over utilization patterns in accordance with CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring and CalOptima Health Policy GG.1541: Utilization Management Delegation.

IV. ATTACHMENT(S)

A. Timeframes for Covered California Service Decisions and Notifications

V. REFERENCE(S)

A. CalOptima Health, Health Network Service Agreement
B. CalOptima Health Contract with Covered California
C. CalOptima Health Policy CC.1400: Behavioral Health Services
D. CalOptima Health Policy CC.1501: Continuity of Care During Health Network or Provider Termination.
E. CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access
F. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
G. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
H. CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
I. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
J. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
K. CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines
L. CalOptima Health Policy GG.1541: Utilization Management Delegation
M. CalOptima Health Utilization Management Program
N. Department of Managed Health Care All Plan Letter (APL) 170-017: Knox-Keene Act Standard for Determining Whether an "Emergency" Existed for Purposes of Provider Reimbursement
O. DMHC APL 21-002: Implementation of SB 855, MH/SUD Coverage
P. DMHC APL 21-004: Transfers of Unstable or Destabilized Enrollees
Q. DMHC APL 24-012: Single Point of Contact for Hospitals to Request Authorization for Post Stabilization Care
R. DMHC APL 24-021: Notice of Amendments to Rules 1300.67.2.1, 1300.67.2 and Incorporated Documents – Network Adequacy Standards and Methodology for RY 2025
S. DMHC APL 24-023: Newly Enacted Statutes Impacting Health Plans (2024 Legislative Session)
T. DMHC APL 23-025 - Newly Enacted Statutes Impacting Health Plans (2023 Legislative Session) – REVISED (2.7.24)
U. Family Code, § 6924
V. Health and Safety Code, §§ 1262.8(j) and (k);1317.1(2)(A) and (B); 1363.5; 1367(d); 1367.01; 1367.31; 1371.4(c) and (e); 1371.5; 1374.16; 1374.30(i); 1374.72; 1374.724; 1383.1; 1383.15
W. National Committee for Quality Assurance (NCQA) HP Standards and Guidelines, MED 9 Element D, Factor 3
X. Title 28, California Code of Regulations, §§ 1300.67.2.2(b); 1300.70(a)(1), (b)(2), (G)(5); 1300.71.4; 1300.74.72(d) and (f)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting

For 02/5/1606 BOD Review Only

06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1600	Authorization and Processing of Referrals	Covered California

For 20250605 BOD Review Only

IX. GLOSSARY

Term	Definition
Authorization	A formal process requiring a Provider to obtain approval for the amount, duration, and scope of non-emergent Covered Services. Authorization can occur prior to, concurrent with, or retrospective to the Covered Services, as specified in this policy.
Authorization Request Form (ARF)	CalOptima Health's form to request authorization for Covered Services
Authorized Representative	An individual who is (1) the legal representative or otherwise legally able to act on behalf of a Member, as the law of the State in which the Member resides may allow; (*e.g.*, court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity), or (2) appointed in writing by a competent Member to act on behalf of the member for a limited purpose (*e.g.*, to represent the member in DMHC Independent Medical Reviews, filing Grievances and Appeals, claims adjudications). The DMHC Authorized Assistant Form may be used to appoint an authorized assistant to assist the Member with Independent Medical Review or complaint, provided a power of attorney for health care decisions or other legal document is submitted by an individual seeking to represent a Member who does not have legal capacity to appoint an authorized assistant.
Behavioral Health Care	Treatment and services provided to treat mental health and substance use disorder conditions.
Behavioral Health Crisis Services	The continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a mental health or substance use disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis receiving and stabilization services in accordance with Government Code § 53123.1.5.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties, or American Osteopathic Association, as meeting the requirements of that board for certification.
Concurrent Review	A review of Medical Necessity of an Authorization request for the Member's treatment regimen that is already in place while the Member is currently in an acute or post-acute setting, or in an ongoing course of care in an outpatient or community setting.
Continuity of Care	Services provided to a Member rendered by an out-of-Network Provider with whom the Member has a pre-existing Provider relationship.
Contracted Provider	A Provider who is contracted with CalOptima Health to provide services to Members.
Covered Services	Health care services that are covered benefits under CalOptima Health's contract with Covered California as further described in the Evidence of Coverage and supporting documents.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or to hold the appropriate qualifications or certifications related to the duty or role.

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Term	Definition
Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services, and supports are in place in the community before individuals leave the hospital or institution 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.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: 1. Placing the patient's health in serious jeopardy. 2. Serious impairment to bodily functions. 3. Serious dysfunction of any bodily organ or part. (Health & Safety Code §1317.1(b))
Emergency Services and Care	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 and Health & Safety Code § 1317.1(a)(1) and §1317(a)(2)(A).
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a health maintenance organization (HMO), subcontractor, or first tier entity, that contracts with CalOptima Health to provide Covered Services to Members.
Initial Emergency Encounter	A Member's presentation to the emergency department for outpatient Emergency Services and Care or the Member's inpatient emergency admission, whichever occurs first.
Medically Necessary or Medical Necessity	Health care and related services and supplies provided to a Member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care Provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results. For treatment of a mental health or substance use disorder, Medical Necessity shall include: A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) in accordance with the generally accepted standards of mental health and substance use disorder care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; (iii) not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care Provider, as required by HSC §1374.72 (a)(3)(A).
Member	An individual enrolled in a CalOptima Health program.

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Term	Definition
Mental Health and Substance Use Disorder	A mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.
Non-Contracted Provider	A Provider who is not contracted with CalOptima Health to provide services under the Member's CalOptima Health plan contract.
Out-of-Area	Outside of CalOptima Health's service area.
Out-of-Network	Health Network: Outside of the selected Health Network's participating provider network within the CalOptima Health's service area. CalOptima Health: A Provider that does not participate in CalOptima Health's Network.
Post-Stabilization Care	Medically Necessary care provided after an Emergency Medical Condition has been Stabilized as defined in Health & Safety Code §1317.1(j).
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	A formal process requiring a Provider to obtain advanced approval for the amount, duration, and scope of non-emergent Covered Services.
Prospective Review	A review of Medical Necessity of an Authorization request for coverage of health care services prior to the provision of Covered Services to Members.
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services.
Psychiatric Emergency Medical Condition	A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following, regardless of whether the patient is voluntary or involuntarily detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment pursuant to the Lanterman-Petris-Short Act: 1. An immediate danger to themselves or to others. 2. Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental health disorder. (Health & Safety Code §1317.1(k)(1)(A))
Referral	The process of a Provider directing a Member to another Provider for care and/or services. A referral may or may not need to be authorized and the Member may be redirected to another Provider from the original requested Provider.

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Term	Definition
Retrospective Review	A form of medical records review that is conducted after the Member's discharge to track appropriateness of care and consumption of resources.
Sanction(s)	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a first tier, downstream, or related entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health programs according to CalOptima Health Policy HH.2002: Sanctions.
Specialist Physician	A physician who has obtained additional education/training in a focused clinical area and does not function as a PCP.
Stabilized/Stabilization	A patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating physician and surgeon, or other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician and surgeon, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient as provided for in Health & Safety Code §§ 1317.2, 1317.2a, or other pertinent statute.
Tertiary Care	Specialized consultative care provided by specialists working in a center with personnel and facilities experienced in handling complex, uncommon or highly complicated diagnostics and treatments, such as organ transplants. Tertiary Care is provided upon Referral from primary or secondary medical personnel and is a level of care that is not available in a community setting.
Urgent Authorization Request	An authorization request required to be addressed within seventy-two (72) hours, as a normal timeframe for authorization will be detrimental to a Member's life or health, and jeopardizes the Member's ability to regain maximum function, or result in loss of life, limb, or other majorly body function.

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For 20250605 BOD Preview Only

Attachment A

TIMFRAMES FOR COVERED CALIFORNIA SERVICE DECISIONS AND NOTIFICATIONS

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Electronic or Written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Routine (Non-urgent) Pre-Service Prospective or outpatient service requests.	Approve, Modify, or Deny within 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 14 calendar days from the receipt of the request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Notice must be postmarked within 2 business days of decision not to exceed 14 calendar days from receipt of the request.
Routine (Non-urgent) Pre-Service – Extension Needed • Additional clinical information required. • Require consultation by an Expert Reviewer. • Additional examination or tests to be performed.	Approve, Modify, or Deny within 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 14 calendar days from the receipt of the request. • The decision may be deferred, and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. • CalOptima Health will notify the Member and practitioner of decision to defer, in writing, within 5 business days of receipt of information reasonably necessary to render a decision, and no longer than 14 calendar days from date of receipt of initial request. • Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. **Practitioner/Member:** Written Notice of Action "Delay" notification within 14 calendar days of receipt of the request for services.
	Additional information received • If requested information is received, decision must be made within 5 business days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.

[1] Business days = Monday through Friday excluding California State Holidays
https://www.calhr.ca.gov/employees/pages/state-holidays.aspx
UM TAT Revised: - 06/05/2025

Attachment A
TIMFRAMES FOR COVERED CALIFORNIA SERVICE DECISIONS AND NOTIFICATIONS

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Electronic or Written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
	Additional information incomplete or not received If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the Member notice of denial.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.
Expedited Authorization (Pre-Service) • Provider or CalOptima Health determines that the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. • All necessary information received at time of initial request.	Approve, Deny, or Modify within 72 hours from receipt of the request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision not to exceed 72 hours from receipt of request. **Member: Written** Within 2 business days of making the decision from the receipt of the request for service.
Expedited Authorization (Pre-Service) - Extension Needed • Extension is extended when a Member or provider requests the extension, or CalOptima Health justifies a need for additional information and can demonstrate how the extension is in the Member's best interest. There is reasonable likelihood that receipt of such information would lead to approval of the request.	Approve, Deny or Modify within 72 hours from receipt of the request **Additional clinical information required:** Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and Member using the "delay" written notification, and insert specifics about what has not been received, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered **Note**: The time limit may be extended by up to 14 calendar days if the Member requests an extension, or CalOptima Health can provide justification upon request by the State for the need for	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision not to exceed 72 hours from receipt of request. **Member: Written** Within 2 business days of making the decision from the receipt of the request for service.

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https://www.calhr.ca.gov/employees/pages/state-holidays.aspx
UM TAT Revised: - 06/05/2025

Attachment A

TIMFRAMES FOR COVERED CALIFORNIA SERVICE DECISIONS AND NOTIFICATIONS

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Electronic or Written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
	additional information and how it is in the Member's interest.		
	Additional information received • If requested information is received, decision must be made within 1 business day of receipt of information.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
	Additional information incomplete or not received • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision.
Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health determines that the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function.	Approve, Modify, or Deny within 72 hours of the receipt of the request. **Extension:** CalOptima Health may extend the time frame, by up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	Approve, Modify, or Deny within 72 hours of last approved day or decision consistent with urgency of Member's medical condition. **Extension:** CalOptima Health may extend the time frame 48 hours or up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner:** **Electronic or Oral:** Within 24 hours of receipt of the request. **Member: Written** Written notification within 2 calendar days of decision. **Note:** If oral notification is given within 24 hours of request, then written/electronic notification must be given no later than 2 calendar days after the oral notification.

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Attachment A

TIMFRAMES FOR COVERED CALIFORNIA SERVICE DECISIONS AND NOTIFICATIONS

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Electronic or Written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request).	Decision within 30 calendar days from receipt of information that is reasonably necessary to make a decision.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 30 calendar days of receipt of the request. **Member: Written** Within 30 calendar days of receipt of request.
Hospice - Inpatient Care	Within 24 hours of receipt of request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Prescription Drugs *Exigent circumstances" exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function OR when an insured is undergoing a current course of treatment using a non-formulary drug.	**Non-urgent:** Within 72 hours of receipt of request. **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request	**Practitioner:** **Non-urgent**: Within 72 hours of receipt of request **Urgent request of exigent circumstances*:** Within 24 hours of receipt of request	**Practitioner:** **Non-urgent**: Within 72 hours of receipt of request **Urgent request of exigent circumstances*:** Within 24 hours of receipt of request

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https://www.calhr.ca.gov/employees/pages/state-holidays.aspx

Policy:	CC.1400
Title:	**Behavioral Health Services**
Department:	Medical Management
Section:	Behavioral Health Integration
CEO Approval:	*/s/*
Effective Date:	01/01/2027
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☒ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250605 BOD Review Only

I. PURPOSE

This policy defines the scope of Behavioral Health Services for Covered California Members.

II. POLICY

A. CalOptima Health shall provide coverage for Medically Necessary treatment of Mental Health and Substance Use Disorders (MH/SUD) under the same terms and conditions applied to other medical/surgical conditions.

B. CalOptima Health shall offer the following Behavioral Health Services:

1. Basic health care services as defined in Title 28 California Code of Regulations (CCR) § 1300.74.72.01(a)(1);
2. Behavioral health treatment for pervasive developmental disorder or autism spectrum disorder pursuant to Health and Safety Code § 1374.73;
3. Coordinated Specialty Care for the treatment of first episode psychosis;
4. Day treatment;
5. Drug testing, both presumptive and definitive, including for initial and ongoing patient assessment during substance use disorder treatment;
6. Electroconvulsive therapy;
7. Gender dysphoria, including all health care benefits identified in the most recent edition of the *Standards of Care* development by the World Professional Association for Transgender Health;
8. Inpatient services, including but not limited to services as specified in 28 CCR § 1300.74.72.01(a)(8);
9. Intensive community-based treatment, including assertive community treatment and intensive case management;

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10. Intensive home-based treatment;

11. Intensive outpatient treatment;

12. Medication management;

13. Narcotic (opioid) treatment programs;

14. Outpatient prescription drugs, if coverage for outpatient prescription drugs is provided;

15. Outpatient professional services, including but not limited to individual, group, and family substance use and mental health counseling;

16. Partial hospitalization;

17. Polysomnography;

18. Psychiatric health facility services, including structured outpatient services pursuant to Health & Safety Code § 1250.2;

19. Psychological and neuropsychological testing;

20. Reconstructive surgery pursuant to Health & Safety Code § 1374.22;

21. Residential treatment facility services including all services as specified in Title 28 CCR § 1300.74.72.01(a)(21);

22. School site services for a mental health condition or substance use disorder that are delivered to a Member at a school site pursuant to Health & Safety Code section 1374.722;

23. Transcranial magnetic stimulation;

24. Withdrawal management services, including all services as specified in 28 CCR § 1300.74.72.01(a)(24);

25. Home health care services, including all services if certain conditions are satisfied as specified in 28 CCR § 1300.74.72.01(b); and

26. Preventive health care services, including all services as specified in 28 CCR § 1300.74.72.01(c).

C. CalOptima Health shall base Medical Necessity determinations or the utilization review criteria to determine the Medical Necessity of health care services and benefits on current generally accepted standards of MH/SUD care in accordance with CalOptima Health Policies GG.1535: Utilization Review Criteria and Guidelines.

1. Generally accepted standards of MH/SUD care mean standards of care and clinical practice that are generally recognized by health care Providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Health and Safety Code § 1374.73. Valid, evidence-based sources establishing generally accepted standards of MH/SUD care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care Provider professional associations, specialty societies and federal

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government agencies, and drug labeling approved by the United States Food and Drug Administration.

D. CalOptima Health shall not impose quantitative or non-quantitative treatment limitations more stringently on covered Behavioral Health Services than are imposed on medical/surgical services in accordance with the parity in MH/SUD requirements in Title 45, Code of Federal Regulations (CFR) § 146.136 and Health & Safety Code § 1374.76.

E. CalOptima Health and its Health Networks' contracted Primary Care Practitioner (PCPs) shall be responsible for screening and providing Behavioral Health Services within the scope of their practice.

F. CalOptima Health and its Health Networks shall maintain the privacy of Member's Protected Health Information (PHI), in accordance with all federal and state laws when using or disclosing PHI for treatment, payment, and health care operation, including applying minimum standards, when applicable, in accordance with CalOptima Health Policies HH.3006: Tracking and Reporting Disclosures of Protected Health Information (PHI), HH.3010: Protected Health Information (PHI) Disclosures Required by Law, and HH.3011: Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations.

G. CalOptima Health and its Health Networks shall obtain written authorization from the Member prior to the use or Disclosure of PHI for purposes other than treatment, payment, and health care operations, in accordance with CalOptima Health Policies HH.3011: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations, and HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information.

H. CalOptima Health shall ensure timely access to Behavioral Health Services as set forth by the Department of Managed Health Care (DMHC) and CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access.

I. If Behavioral Health Services that are the responsibility of CalOptima Health are unavailable to the Member, CalOptima Health shall arrange for the provision of Behavioral Health Services outside the network in a timely manner, and in accordance with CalOptima Health Policies CC.1600: Authorization and Processing of Referrals, and GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

J. CalOptima Health shall not require a referral from a PCP or Prior Authorization for an initial outpatient mental health assessment performed by a contracted mental health Provider.

K. CalOptima Health shall ensure that all contracted and non-contracted mental health Providers are informed of the Prior Authorization and referral process. Prior Authorization requirements for services covered by CalOptima Health shall be in compliance with the requirements for parity in MH/SUD benefits in 45 CFR § 146.136.

L. CalOptima Health shall follow authorization guidelines in accordance with CalOptima Health Policies GG.1535: Utilization Review Criteria and Guidelines, CC.1600: Authorization and Processing of Referrals, and GG.1501: Inpatient Length of Stay Assignment, when authorizing Behavioral Health Services.

M. CalOptima Health shall maintain a twenty-four (24) hour/seven (7) days per week direct telephone line for emergencies and assistance during non-business hours which is staffed by trained and licensed mental health professionals, or supervised by a licensed mental health professional, for appropriate crisis intervention and initial referrals to mental health Providers in accordance with CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access.

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N. CalOptima Health and its Health Networks shall implement a mechanism for the identification and referral of quality of care and service delivery issues to CalOptima Health's Quality Improvement (QI) Department in accordance with CalOptima Health Policy GG.1629: Quality Improvement and Health Equity Transformation Program (QIHETP).

O. CalOptima Health shall be responsible for the MH/SUD benefits including administrative functions and responsibility for authorizing Medically Necessary MH/SUD services. CalOptima Health shall process requests for authorization in compliance with state and federal laws and regulatory requirements. CalOptima Health will not delegate such functions and responsibilities to a contracted entity.

III. PROCEDURE

A. Medical Provider responsibilities for basic and preventive health care services and the screening, referral and intervention for MH/SUD services as defined in Title 28 CCR § 1300.74.72.01, include, but are not limited to, the following:

1. For substance use disorder services, Providers within their scope of practice shall:

   a. Administer an approved screening tool for identifying unhealthy alcohol or drug use;

   b. Provide behavioral counseling or brief intervention on identified issue(s);

   c. Provide a Member referral to SUD treatment, primary care-based interventions, and specialty services when there is a need beyond screening or counseling interventions;

   d. Refer a Member for additional assessment and counseling, if necessary;

   e. Refer a Member to additional community resources when needed and/or when services are not available.

   f. Access the CalOptima Health Behavioral Health Line for any assistance needed.

2. For mental health services, Providers within their scope of practice shall:

   a. Screen and provide mental health services; and/or

   b. Refer a Member for further mental health services through the CalOptima Health Behavioral Health Line as needed.

B. Accessing CalOptima Health Behavioral Health Services

1. A Member may access Behavioral Health Services through the CalOptima Health Behavioral Health Line for assistance with obtaining a mental health assessment from a licensed mental health Provider within CalOptima Health's Provider network at any time.

2. A Member may be referred to the CalOptima Health Behavioral Health Line from the following:

   a. Self-referral;

   b. Authorized Representative or caregiver;

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c. PCP or another medical Provider;

d. Specialty Care Provider;

e. Behavioral health Provider, including clinical psychologist, clinical social worker, marriage and family therapists, autism service Provider, and MH/SUD Providers, which may include mental health counselors/clinical professional counselors, opioid treatment program Providers, community mental health centers, and those who regularly furnish or will regularly furnish behavioral health counseling or therapy services;

f. Community-based agency;

g. Internal CalOptima Health departments, including Customer Services; and

h. Other Providers who are part of a Member's health care team.

C. CalOptima Health Behavioral Health Integration Call Center

1. CalOptima Health Behavioral Health Line Number: (855) 877-3885

2. CalOptima Health Behavioral Health Line requirements shall include:

a. 24 hours/7 days-a-week availability in compliance with telephone access standards in accordance with CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access;

b. Utilizing linguistic interpreter services, or the California Relay Service (711) for Members, as necessary to ensure effective communication;

c. Verifying the caller's eligibility and Health Network assignment;

i. If the caller is not a Covered California Member and not in crisis, call center staff shall refer the caller to his/her health insurance and suggest a community resource for treatment of their described symptoms.

d. Identifying and triaging callers based on their initial reason for contacting the CalOptima Health Behavioral Health Line;

e. Screening and determination for routine, urgent or emergent needs. If determined urgent or emergent, call center staff shall immediately complete safety screening;

i. If a caller's needs are indicated as requiring Emergency Services and Care or Urgent Services, call center staff shall make a referral to Orange County Health Care Agency's Centralized Assessment Team (CAT) and/or contact other appropriate emergency agencies;

ii. Call center staff must link emergent calls immediately and/or not more than two (2) hours after the determination that the call is emergent;

iii. Call center staff must link urgent calls for services within twenty-four (24) hours after making the determination that the call is urgent;

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iv. Call center staff must obtain confirmation and document that any caller assessed as requiring Emergency Services and Care or Urgent Services has been appropriately connected to services and/or the appropriate agencies; and

f. If the caller is determined to be a Member with a mental health need, the call center licensed behavioral health clinicians shall conduct a clinical screening to determine the appropriate level of service.

3. Screening and Assessment:

a. If it is determined the Member needs Behavioral Health Services, the call center staff will provide the Member with referrals to appropriate Behavioral Health Services. The call center staff will ensure the Member is directed to Providers that are within the CalOptima Health behavioral health network, are currently accepting CalOptima Health Covered California Members, can provide appropriate cultural and linguistic services, and can offer a first appointment within the standards pursuant to CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access.

b. CalOptima Health reviews and updates triage and referral protocols on MH/SUD parity conditions on a regular basis in accordance with CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines.

D. Prior Authorization

1. CalOptima Health shall process requests for Prior Authorization within the timeframes specified in CalOptima Health Policy CC.1600: Authorization and Processing of Referrals. CalOptima Health shall maintain appropriate communication with the Member, the Member's Authorized Representative, and Provider, throughout the Prior Authorization process to facilitate delivery of appropriate services.

a. General Standards

i. If CalOptima Health does not take action by approving, denying, deferring, or modifying services, on a routine written request for Prior Authorization of Covered Services within the required timeframe after receipt, such request shall be deemed denied by default and a notification of denial for the requested service is sent to the Provider and Member in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

a) CalOptima Health shall maintain a system for tracking all referrals for Provider and Member-requested health care services and supplies in accordance with CalOptima Health Policy CC.1600 .

ii. A Practitioner or other Provider shall request Prior Authorization for services for a Member, in accordance with CalOptima Health Policy CC.1600: Authorization and Processing of Referrals.

iii. Services Excluded from the Prior Authorization Process

a) As specified in Policy CC.1600: Authorization and Processing of Referrals, Emergency Services and Care to treat an Emergency Medical Condition, including a Psychiatric Emergency Medical Condition, do not require Prior Authorization, and requests for Post-Stabilization Care will be processed as specified in that policy."

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1) CalOptima Health shall not require notification for Emergency Services and Care and does not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

2) CalOptima Health shall not refuse to cover Emergency Services and Care based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's PCP or CalOptima Health of the Member's screening and treatment.

3) In determining whether to pay for Emergency Services and Care, CalOptima Health and its Health Networks shall follow the standard of whether the Member had a reasonable belief that an emergency existed, in accordance with Health & Safety Code § 1371.4(c) and the DMHC All Plan Letter (APL) 17-017: Knox-Keene Act Standard for Determining Whether An "Emergency" Existed For Purposes of Provider Reimbursement.

4) CalOptima Health shall treat a Psychiatric Emergency Medical Condition as an Emergency Medical Condition, under which the use of Prior Authorization would be prohibited in accordance with CalOptima Health Policy CC.1500: Continuity of Care for Members Transitioning into CalOptima Health.

b) Behavioral Health Crisis Services

1) Coverage of MH/SUD treatment pursuant to Health & Safety Code § 1374.72 includes Medically Necessary treatment of a MH/SUD, including, but not limited to, Behavioral Health Crisis Services, provided to a Member by a 988 center or mobile crisis team regardless of whether the service is provided by an in-network or out-of-network Provider.

2) CalOptima Health shall not require Prior Authorization for medical Medically Necessary treatment of a MH/SUD services provided by a 988 center, mobile crisis team, or other Provider of Behavioral Health Crisis Services, in accordance with Health & Safety Code § 1374.724.

iv. Hospital Services

a) A hospital shall notify CalOptima Health of a Member's inpatient admission within twenty-four (24) hours of the admission.

b) All initial requests for an inpatient stay will be acknowledged within twenty-four (24) hours of receipt of the request by providing a CalOptima Health tracking number to the facility.

c) A decision will be made on an initial request within seventy-two (72) hours of the request.

d) Concurrent review will be completed within seventy-two (72 hours) of last approved day or decision consistent with urgency of Member's medical condition.

v. Provider

a) The hospital Provider shall provide care coordination with the Member's PCP and behavioral health specialist as appropriate.

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b) Hospital/Provider shall coordinate timely discharge planning so that the Member's anticipated needs are met, and discharge plan is continued to the next appropriate level of care following facility discharge.

vi. Additional Assistance After Discharge

a) CalOptima Health shall outreach to Members after discharge to assist with coordination needs including but not limited to benefits, services, and community resources.

vii. Out-of-Network Services

a) CalOptima Health shall maintain a Provider network sufficient to provide all Medically Necessary MH/SUD services, within geographic and timely access standards, pursuant to the Knox-Keene Act and its implementing regulations and in accordance with CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access.

b) If MH/SUD services are not available to a Member in accordance with geographic and timely access standards as specified in CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access, CalOptima Health shall provide and arrange coverage for Medically Necessary MH/SUD services from an out-of-network Provider or Providers. In such cases, CalOptima Health shall:

1) Issue a written notice to the Member, the Member's Authorized Representative (if any) and the requesting Provider (if any) within five (5) calendar days following the initial request for in-network MH/SUD services, which shall include a statement in accordance with Title 28 CCR § 1300.74.72.

viii. CalOptima Health shall select and contact an out-of-network Provider or Providers who are qualified and available to provide the MH/SUD services the Member needs. Such Provider(s) shall be located consistently with the geographic access standards in 28 CCR § 1300.67.2.1, if possible. Within three (3) business days of when CalOptima Health contacts the selected Provider, CalOptima Health shall furnish a written authorization to the Provider specifying, at a minimum, the following:

a) Provider name;

b) Service authorization number;

c) Services authorized;

d) Negotiated reimbursement rate(s);

e) Date range for the authorization;

f) CalOptima Health's contact and claims submission information; and

g) CalOptima Health's Provider dispute resolution information. CalOptima Health shall document and retain a record of this communication.

ix. CalOptima Health shall schedule the appointment for the Member or arrange for the admission of the Member if the MH/SUD services will be in an inpatient (including residential) setting, when accepted by the Member, and in accordance with CalOptima

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Health Policy CC.1700: Standards of Accessibility and Timely Access. If the Member is unable to attend the appointment offered by CalOptima Health, CalOptima Health shall continue to arrange and schedule a new appointment with the same out-of-network Provider or a different out-of-network Provider to ensure the delivery of Medically Necessary MH/SUD services.

x. Within twenty-four (24) hours of scheduling the appointment or admission, CalOptima Health shall communicate the following information in the most expeditious manner possible to the Member, the Member's Authorized Representative, or the Member's treating Provider:

a) CalOptima Health has scheduled the appointment or admission;

b) Provider name;

c) Date and time of the appointment or admission; and,

d) Location and contact information for the Provider.

xi. CalOptima Health shall document and retain a record of all communications with the Member pursuant to 28 CCR § 1300.74.72 (c), including a description of the requested MH/SUD services, the name and location of the Provider(s) contacted, the date(s) the plan contacted the Provider(s), the type of Provider(s), the MH/SUD service(s) authorized, and the selected Provider(s), location(s), and duration of the MH/SUD service(s) provided.

xii. The limit on the Member's financial obligation for out-of-network MH/SUD services pursuant to Health and Safety Code § 1374.72(d), which shall be set forth in the written agreement between CalOptima Health and the out-of-network Provider(s). CalOptima Health shall contact the Member in writing to explain the Member's financial obligation to the out-of-network Provider(s).

xiii. CalOptima Health or a Health Network shall arrange for a Letter of Agreement with an identified out-of-network Provider, in accordance with CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts.

xiv. If out-of-network coverage is arranged, CalOptima Health shall reimburse the Provider for the entire course of Medically Necessary services to treat the Member's MH/SUD, including follow up MH/SUD services in accordance with Health and Safety Code § 1374.72(d), unless there is an in-network, timely and geographically accessible Provider and all of the following criteria are satisfied: the Provider can deliver the MH/SUD services to the Member, requiring the Member to transition to the in-network Provider would not harm the Member, and transitioning Providers is within the standard of care for the Member's MH/SUD condition at the time of the transition. CalOptima Health shall be responsible for making the determination in accordance with good professional practice and with the clinical standards set forth in Health and Safety Code § 1374.721 and § 1374.722, that the requirements of 28 § 1300.74.72(e) are satisfied and shall retain a record of the determination and underlying analysis, rationale, record, and other supporting information.

xv. Before CalOptima Health may transition a Member to an in-network Provider, CalOptima Health shall provide the Member, the Member's Authorized Representative (if any), and the Member's treating Provider(s) with at least ninety (90) calendar days' notice. The notice shall inform the Member of the following:

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a) Name and contact information of the in-network Provider to which CalOptima Health intends to transition the Member; and,

b) Information about how the Member may file a Grievance with CalOptima Health if the Member, the Member's Authorized Representative, or Member's Provider believes transitioning the Member to an in-network Provider will harm the Member or is not within the standard of care.

xvi. If the Member or the Member's Authorized Representative expresses dissatisfaction to the transition to an in-network Provider, CalOptima Health shall treat that objection as a Grievance, in accordance with CalOptima Health Policy CC.1201: Member Grievance.

xvii. CalOptima Health shall preserve the books and records required under 28 § 1300.74.72 for a period of not less than five (5) years, the last two (2) years of which shall be in an easily accessible location at CalOptima Health's headquarters.

b. Prior Authorization Procedure

i. CalOptima Health's Behavioral Health (BH) Utilization Management (UM) unit shall provide Members, or potential Members, and/or Providers access to information, about the BH UM process, and the process for authorizing care, in the Covered California Member Handbook/Evidence of Coverage and Provider Manual, available in-print and on the CalOptima Health website at www.caloptimahealth.org.

c. Denials, Dismissals, and Modifications of Prior Authorization Requests

i. CalOptima Health shall make UM decisions based only on appropriateness of care and service, and existence of coverage.

ii. In the event a Prior Authorization request is denied, delayed, dismissed, modified, or alternative treatment is recommended, CalOptima Health or a Health Network shall notify in writing the Member, the Member's Authorized Representative, and the Provider of the reason for the action in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

iii. The written communication must be sent within five (5) calendar days of the decision for non-urgent care and seventy-two (72) hours for urgent care. The written communication shall include the following information:

a) The Member's MH/SUD condition(s) for which CalOptima Health conducted UM review;

b) The clinical specialty at issue;

c) A list of all criteria and guidelines (*e.g.*, CALOCUS-CASII for Mental Health Disorders in Patients Under the Age of Eighteen) used, including any nonprofit professional association criteria, criteria outside the scope of the nonprofit professional association criteria, or criteria that relate to advancements in technology or types of care not covered in the most recent versions of the nonprofit professional association criteria;

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d) A summary of the reasons for deviating from the criteria listed in 28 CCR § 1300.74.721, if applicable; and

e) A summary of CalOptima Health's clinical reason(s) for its decision, including providing full details of CalOptima Health's application of and/or scoring using the criteria listed in 28 CCR § 1300.74.721.

E. Exchange of Protected Health Information

1. All Providers rendering services to the Member shall ensure that only the minimum information necessary will be exchanged in accordance with the terms and conditions of this policy and CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosures of Protected Health Information (PHI) and Document Controls, in order to protect the Member's privacy to the fullest extent. This information will be exchanged in an effort to provide coordination between medical and behavioral health services.

2. CalOptima Health shall ensure that there is a release of information signed by the Member. The form shall:

a. Be signed within the current Episode of Care (EOC), established either upon the opening of a new Member case or if currently under CalOptima Health care, as discovered during Member's annual medical visit;

b. Identify CalOptima Health and/or other program(s) providing services in which information should be shared;

c. Identify which types of information can be shared;

d. Be placed in the Member's chart along with other releases of information; and

e. Be void at the end of the current EOC and require renewal upon each new EOC.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Department of Managed Health Care (DMHC) APL 17-017: Knox-Keene Act Standard for Determining Whether An "Emergency" Existed For Purposes of Provider Reimbursement
B. California Department of Managed Health Care (DMHC) APL 21-002: Implementation of SB 855, MH/SUD Coverage
C. California Department of Managed Health Care (DMHC) APL 23-025: Newly Enacted Statutes Impacting Health Plans (2023 Legislative Session) – REVISED (2.7.24)
D. California Department of Managed Health Care (DMHC) APL 24-007: SB 855 Regulation Implementation
E. CalOptima Health Contract with Covered California
F. CalOptima Health Policy CC.1201: Member Grievance
G. CalOptima Health Policy CC.1500: Continuity of Care for Members Transitioning into CalOptima Health
H. CalOptima Health Policy CC.1600: Authorization and Processing of Referrals
I. CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access
J. CalOptima Health Policy GG.1501: Inpatient Length of Stay (LOS) Assignment

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K. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
L. CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines
M. CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosures of Protected Health Information (PHI) and Document Controls
N. CalOptima Health Policy HH.3006: Tracking and Reporting Disclosures of Protected Health Information (PHI)
O. CalOptima Health Policy HH.3010: Protected Health Information Disclosures Required by Law
P. CalOptima Health Policy HH.3011: Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations
Q. CalOptima Health Policy HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)
R. CalOptima Health Utilization Management Program
S. Health & Safety Code § 1374.72
T. Health & Safety Code § 1374.721
U. Health & Safety Code § 1374.724
V. Title 28 Code of California Regulations (CCR) § 1300.74.72
W. Title 28 Code of California Regulations (CCR) § 1300.74.72.01

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1400	Behavioral Health Services	Covered California

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IX. GLOSSARY

Term	Definition
Appeal	A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in Health & Safety Code § 1367.01.
Authorized Representative	An individual who is (1) the legal representative or otherwise legally able to act on behalf of a Member, as the law of the State in which the Member resides may allow; (*e.g.*, court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity), or (2) appointed in writing by a competent Member to act on behalf of the Member for a limited purpose (*e.g.*, DMHC Independent Medical Reviews, filing Grievances and Appeals, claims adjudications). The DMHC Authorized Assistant Form may be used to appoint an authorized assistant to assist the Member with Independent Medical Review or complaint, provided a power of attorney for health care decisions or other legal document is submitted by an individual seeking to represent a Member who does not have legal capacity to appoint an authorized assistant.
Behavioral Health Crisis Services	The continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a mental health or substance use disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis receiving and stabilization services in accordance with Government Code section 53123.1.5.
Behavioral Health Services	Services which encompass both Mental Health and Substance Use Disorder services and applied behavioral analysis, as covered by CalOptima Health.
CalOptima Health Behavioral Health Line	Toll-free telephone number that Providers, Members or individuals acting on behalf of Members can call at any time (twenty-four (24) hours/ seven (7) days a week) to obtain referrals for all CalOptima Health Covered outpatient mental health services. This line has a live operator at all times and telephone coverage shall be made available in all threshold languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either: 1. Have authority to approve Covered Services; 2. Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and/or 3. In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room.
Complaint	A complaint is the same as a Grievance, as defined below.
Covered Services	Health care services covered under the CalOptima Health Covered California contract, as provided in the Evidence of Coverage and supporting documents.

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Term	Definition
Department of Managed Health Care (DMHC)	California state agency that regulates and oversees health maintenance organizations (HMOs) and other managed care plans.
Grievance	A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A Complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: 1. Placing the patient's health in serious jeopardy. 2. Serious impairment to bodily functions. 3. Serious dysfunction of any bodily organ or part. (Health & Safety Code §1317.1(b))
Emergency Services and Care	Medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. Also includes an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition, within the capability of the facility. The care and treatment necessary to relieve or eliminate a Psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a general acute care hospital, as defined in Health and Safety Code § 1250(a), or to an acute psychiatric hospital, as defined in Health & Safety Code § 1250(b). This subparagraph does not permit a transfer that is in conflict with the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), or the federal Emergency Medical Treatment and Labor Act (Section 1395dd of Title 42 of the United States Code).

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Term	Definition
Psychiatric Emergency Medical Condition	A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following, regardless of whether the patient is voluntary or involuntarily detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment pursuant to the Lanterman-Petris-Short Act: 1. An immediate danger to themselves or to others. 2. Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental health disorder. (Health & Safety Code §1317.1(k)(1)(A))
Episode of Care (EOC)	The set of services provided to treat a clinical condition or procedure.
Health Network	A physician hospital consortium (PHC), physician group under a shared risk contract, health care service plan, such as a health maintenance organization (HMO), subcontractor, or first tier entity, that contracts with CalOptima Health to provide Covered Services to Members.
Medically Necessary/ Medical Necessity	Health care and related services and supplies provided to a Member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care Provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results. For treatment of a mental health or substance use disorder, Medical Necessity shall include a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) in accordance with the generally accepted standards of mental health and substance use disorder care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; and (iii) not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care Provider, as required by Health and Safety Code §1374.72 (a)(3)(A).
Member	An individual enrolled in the CalOptima Health program.
Mental Health and Substance Use Disorder	A mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care Providers practicing in relevant clinical specialties.

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Term	Definition
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Primary Care Practitioner (PCP)	A Practitioner, including a physician, responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities , "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA)) authorized to provide primary care services under supervision of a physician.
Prior Authorization	A process through which a physician or other health care Provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Protected Health Information (PHI)	Has the meaning at 45 CFR § 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	Any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.
Specialist Physician	A physician who has obtained additional education/training in a focused clinical area and does not function as a Primary Care Physician.
Specialty Care	Refers to higher-level medical services that require a referral from a primary care Provider. Physicians who provide specialty care undergo extensive training to "specialize" in a given area of medicine, for example, oncology, cardiology, etc.
Urgent Services	For purposes of this policy, shall be indicated with a situation experienced by a caller that, without timely intervention, is highly likely to result in an immediate Psychiatric Emergency Medical Condition. Callers in need of Urgent Services shall receive timely mental health intervention that shall be appropriate to the severity for the condition.

For 20250605 BOD Review Only

Policy:	CC.1500
Title:	**Continuity of Care for Members Transitioning into CalOptima Health**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/*
Effective Date:	01/01/2027
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☒ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250605 BOD Review Only

I. PURPOSE

This policy establishes continuity, timeliness, and coordination of care procedures between and among Providers (including mental health Providers, specialists, facilities, medical groups, case management staff, and others); timely communication of clinical information among providers; transitions of care; and, co-payments, deductibles, or other cost sharing requirements during the period of a completion of Covered Services with a Nonparticipating Provider.

II. POLICY

A. CalOptima Health provides Covered Services in a manner providing Continuity of Care and ready referral of patients to other Providers at times as may be appropriate consistent with good professional practice and includes physical health and behavioral health delivery of care and services.

B. CalOptima Health and its Health Networks shall comply with the provisions of this policy, as applicable.

C. CalOptima Health shall include on its Internet Web site a detailed description of, or a link to, how a Member may request Continuity of Care.

D. A Member is not required to request Continuity of Care to maintain their Primary Care Provider (PCP) assignment with PCPs that are part of CalOptima Health's or a Health Network's in-network Providers.

E. If the Member's PCP is a Non Participating Provider, CalOptima Health or a Health Network is not required to maintain that agreement.

F. CalOptima Health or a Health Network shall provide Continuity of Care to extend to Primary Care Providers (PCPs), specialists, mental and behavioral health Providers, including substance use disorder Providers, and select ancillary Providers, including:

1. Physician services;

2. Inpatient Hospital services;

3. Ambulatory care services (outpatient Hospital services);

4. Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services, which shall include, but not be limited to, electrocardiography and electroencephalography;

5. Home health services;

6. Preventive health services;

7. Emergency health care services;

8. Urgently needed services; and

9. Hospice services.

J. CalOptima Health or a Health Network shall provide Continuity of Care for a Member seen by a traditional or safety-net Provider upon entry into CalOptima Health or a Health Network, to the extent possible.

K. Supporting At-Risk Members Requiring Transition

1. CalOptima Health and its Health Networks provide coordination and support to At-Risk and High-Risk Member, as defined in this policy, transitioning from one Covered California plan to CalOptima Health, or from CalOptima Health to another Covered California plan.

2. In the event of a service area reduction such that CalOptima Health withdraws any existing, approved networks from any geographic region or modifies any portion of its service area, CalOptima Health shall comply with an Enrollee Transition Plan to facilitate transitions of care with minimal disruption for At-Risk and High-Risk Covered California Members who are transitioning from one Qualified Health Plan (QHP) Issuer to another QHP Issuer.

3. If CalOptima Health receives Covered California Members from another QHP Issuer pursuant to a service area reduction, CalOptima Health shall facilitate transitions of care in accordance with this policy.

L. If CalOptima Health or a Health Network is unable to provide Covered Services through a Network Provider, services shall be arranged through a Non Participating Provider, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

M. An Non Participating Provider approved to provide continuing treatment must work with CalOptima Health and its contracted network and cannot refer the Member to another Non Participating Provider without Prior Authorization from CalOptima Health or the Member's Health Network.

N. CalOptima Health shall inform Members of the Continuity of Care protections and how to initiate a Continuity of Care request in written Member materials, including but not limited to, the Member Handbook, the Evidence of Coverage, all disclosure notices, upon request, on the CalOptima Health website at www.caloptima.org, in termination notices sent in the circumstances provided in Section II.A.2 of this policy, and the Member newsletter.

O. CalOptima Health and its Health Networks shall provide written information on how to request Continuity of Care to its contracting Providers and Provider Groups.

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P. CalOptima Health or a Health Network shall provide training to call center staff who come into regular contact with Members about the Continuity of Care requests and protections.

III. PROCEDURE

A. Covered California Members Transitioning to CalOptima Health

1. Data Transfers: CalOptima Health shall receive from Covered California the secure transfer of personal health information submitted by a departing QHP Issuer, enrollment records, and any other relevant data necessary to ensure no disruption in coverage and services for Covered California Members.

   a. CalOptima Health shall give special attention to At-Risk and High-Risk Members, ensuring their transition is managed with the highest priority and sensitivity to prevent any lapse in necessary medical care or services.

   b. CalOptima Health shall ensure appropriate Continuity of Care for Covered California Members, thereby minimizing any potential impact on their ongoing treatment and health outcomes.

2. If CalOptima Health receives terminating Covered California Members from another QHP Issuer pursuant to a service area reduction, CalOptima Health shall:

   a. Identify At-Risk Members, using existing CalOptima Health practices and through receipt of both health information from the prior QHP Issuer and the data file with transitioning enrollment information from Covered California (after the effectuation of coverage).

   b. Engage and conduct outreach to Covered California Enrollees including At-Risk Members within sixty (60) days of receiving health information from the departing QHP Issuer or Covered California to ensure Continuity of Care and minimal to no disruption to health services.

   c. Ensure At-Risk Members' care transitions account for their medical situation, including participation in case or disease management programs, locating in-network Providers with appropriate clinical expertise, and any alternative therapies, including specific drugs.

   d. Establish internal processes to ensure all parties involved in the transition of care for At-Risk Members are aware of their responsibilities. This includes anyone within or outside of CalOptima Health who is needed to ensure the transition of prescriptions or provision of care.

   e. Provide information on Continuity of Care programs, including alternatives for transitioning to an in-network Provider.

   f. Consider receipt of High-Risk Member health information as the Member's request for Continuity of Care pursuant to Health and Safety Code § 1373.96 and in accordance with this policy.

   g. Ensure new At-Risk Members have access to CalOptima Health's formulary information prior to enrollment.

B. At the request of a newly enrolled Member, CalOptima Health and its Health Networks shall arrange for the completion of Covered Services by a Nonparticipating Provider if:

1. The Member's prior coverage was terminated due to a health benefit plan's withdrawal from the market under the circumstances described in California Health and Safety Code § 1365(a)(5) or (6);

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and

2. At the time the Member's coverage became effective, the newly enrolled Member was receiving services from a Nonparticipating Provider for one of the conditions and durations described in Section III.E.6. of this policy.

C. CalOptima Health or a Health Network shall accept requests for Continuity of Care over the telephone, by facsimile, or by mail, according to the requestor's preference, from the following sources:

1. Member;

2. Authorized Representative of the Member; or

3. Provider.

D. CalOptima Health or a Health Network shall assist an affected Member in completing a request for Continuity of Care, as needed.

E. Authorization for Continuity of Care

1. Upon identification of a Member with a Continuity of Care need, or upon receipt of a Member's request for Continuity of Care, CalOptima Health or a Health Network shall collect the affected Member's Medical Records and other information necessary to review the request for Continuity of Care.

2. When a request for Continuity of Care is made, CalOptima Health or a Health Network shall initiate the review process within five (5) business days after receipt of the request.

a. The Continuity of Care process begins when CalOptima Health or a Health Network starts to determine if there is a pre-existing relationship and enters into an agreement with the Provider.

3. CalOptima Health or a Health Network shall give reasonable consideration to the potential clinical effects on an affected Member's Treatment caused by a change in Provider, or Practitioner, and shall consider the following criteria in adjudicating a request for Continuity of Care:

a. Determine if the affected Member has one of the conditions described in Section III.E.6 of this policy;

b. Determine if the affected Member is in active Treatment for such condition;

c. Determine if the affected Member can safely transition to a participating Provider, or practitioner, instead of continuing care with the Nonparticipating Provider, or practitioner; and

d. Determine if transitioning the affected Member to a new Provider, or practitioner, would compromise the Treatment plan, or worsen the condition of the affected Member.

4. CalOptima Health or a Health Network shall make a decision on the request for Continuity of Care within the time frames specified:

a. Thirty (30) calendar days from the date the request received; or

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b. Fifteen (15) calendar days if the Member's medical condition requires more immediate attention; or

c. Three (3) calendar days if there is risk of harm to the Member.

5. CalOptima Health or a Health Network shall notify an affected Member of its decision to approve, or deny, a request for Continuity of Care within seven (7) calendar days and include the following:

a. Statement of decision;

b. Duration of the Continuity of Care arrangement;

c. The process that will occur to transition the Member's care at the end of the Continuity of Care period; and

d. The Member's right to choose a different Network Provider.

6. If CalOptima Health or a Health Network approves Continuity of Care for an affected Member, CalOptima Health or the Health Network shall provide Continuity of Care as follows:

Condition, as defined	**Completion of Covered Services shall be provided**
Acute Condition, including mental health conditions	For the duration of the Acute Condition, not to exceed twelve (12) months from the effective date of coverage
Serious Chronic Condition, including mental health conditions	For a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by CalOptima Health in consultation with the Member and the terminated Provider or Nonparticipating Provider and consistent with good professional practice, and not to exceed twelve (12) months from the effective date of coverage
A Pregnancy	For the duration of the Pregnancy
A Mental Health Condition, if written documentation of a maternal mental health diagnosis from the Member's treating health care Provider is presented	Not to exceed twelve (12) months from the diagnosis or from the end of Pregnancy, whichever occurs later
A Terminal Illness	For the duration of the Terminal Illness, which may exceed twelve (12) months from the effective date of coverage
Care of a newborn child between birth and age 36 months	Not to exceed twelve (12) months from the effective date of coverage

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Condition, as defined	Completion of Covered Services shall be provided
Performance of a surgery or other procedure that is authorized by CalOptima Health as part of a documented course of treatment and has been recommended and documented by the Provider	To occur within one hundred eighty (180) days of the effective date of coverage

7. If CalOptima Health or a Health Network denies Continuity of Care for an affected Member, CalOptima Health or the delegated Health Network shall request an affected Member's Medical Records from the Provider, Practitioner, mental/behavioral health professional, or substance use disorder Provider and shall coordinate the transfer of such Medical Records and the transition plan to the contracting Provider, or Practitioner, to whom the affected Member is transitioning. CalOptima Health or the Health Network shall ensure that there is no delay in the affected Member's care.

F. A Continuity of Care request is considered completed when:

1. The Member is informed of their right to continued access or if CalOptima Health or a Health Network and the Out-of-Network Provider are unable to agree to terms;

2. CalOptima Health or a Health Network has documented quality of care issues with the Provider; or

3. CalOptima Health or a Health Network makes a good faith effort to contact the Provider, and the Provider is non-responsive for thirty (30) calendar days.

G. If CalOptima Health, or the Health Network are unable to reach an agreement on terms or a reimbursement rate, or there is documented quality of care issues with the Provider, CalOptima Health, or a Health Network shall offer the Member an in-network Provider alternative.

H. CalOptima Health, or the Health Network shall notify the Member thirty (30) calendar days before the end of the Continuity of Care period about the process that will occur to transition the Member's care at the end of the Continuity of Care period. This process shall include engaging with the Member and provider before the end of the Continuity of Care period to ensure continuity of services to the new Provider.

I. Provision of Covered Services

1. CalOptima Health or a Health Network shall allow a Member to change to an in-network Provider at any time regardless of whether or not a Continuity of Care relationship has been established.

2. CalOptima Health and its Health Networks may require a Nonparticipating Provider whose services are continued pursuant to this policy for a newly enrolled Member to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting Providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the Nonparticipating Provider, including, but not limited to, credentialing, Hospital privileging, utilization review, peer review, and quality assurance requirements. If the non-participating Provider does not agree to comply or does not comply with these contractual terms and conditions, CalOptima Health and its Health Networks shall not continue the Provider's services.

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3. Unless otherwise agreed upon by the Nonparticipating Provider and CalOptima Health or by the Nonparticipating Provider and CalOptima's Health Network, the services rendered pursuant to this policy shall be compensated at rates and methods of payment similar to those used by CalOptima Health or its Health Network for currently contracting Providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the Nonparticipating Provider. CalOptima Health or a Health Network shall not continue the services of a Nonparticipating Provider if the Provider does not accept the payment rates provided for in this paragraph.

4. If a Non-Contracted Provider or practitioner does not agree to comply, or does not comply, with the contractual terms and conditions as described in Section III.I.2. of this policy, or if such Provider or practitioner does not accept the contract rate offered by a Health Network as described in Section III.I.3. of this policy, the Health Network shall notify CalOptima Health of the Provider's or practitioner's refusal prior to transitioning an affected Member's care.

5. Neither CalOptima Health nor the noncontracting Provider shall require a CalOptima Health Member to pay a copayment, deductible, or other cost-sharing component during the period of completion of Covered Services other than what would be required if the Member were receiving care from a Provider currently contracting with or employed by CalOptima Health or its Health Networks.

6. CalOptima Health or a Health Network shall not provide for the completion of Covered Services by a Non-Contracted Provider or practitioner if such Non-Contracted Provider's or practitioner's contract has been terminated for reasons relating to a medical disciplinary cause of reason, as defined in paragraph six (6) of subdivision (a) of Section 805 of the Business and Profession Code, Fraud or other criminal activity.

7. CalOptima Health or a Health Network shall not cover services or benefits that are not otherwise covered under the Member's CalOptima Health plan contract.

J. Members shall be notified of a denied Continuity of Care decision, in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

K. If the Member does not agree with the result of the Continuity of Care process, they retain the right to pursue a grievance, in accordance with CalOptima Health Policy CC.1201: Member Grievance.

L. Health Networks shall report all requests and outcomes from former Medi-Cal Fee-for-Service (FFS) and former Covered California enrollees asking to remain with their PCPs, or specialty care Providers, to CalOptima Health's Health Network Relations Department in a format and at a frequency prescribed by CalOptima Health.

M. CalOptima Health's Customer Service and Case Management Departments shall track and follow up on Continuity of Care requests and outcomes made directly to CalOptima Health.

N. CalOptima Health's Customer Service, Health Network Relations, and Case Management Departments shall submit their Continuity of Care reports to CalOptima Health's Regulatory Affairs & Compliance (RAC) Department.

O. CalOptima Health may impose Sanctions on a Health Network, including and without limitation, financial penalties or termination, in accordance with CalOptima Health Policy HH.2002: Sanctions, if the Health Network fails to comply with the requirements of this policy.

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IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Health and Safety Code §§ 1367(d), 1373.95, 1373.96, 1374.73
B. CalOptima Health Contract with Covered California
C. CalOptima Health Policy CC.1201: Member Grievance
D. CalOptima Health Policy CC.1600: Authorization and Processing of Referrals
E. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
F. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of- Area Services
G. Title 28, California Code of Regulations §§ 1300.67.1 and 1300.80

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1500	Continuity of Care for Members Transitioning into CalOptima Health	Covered California

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IX. GLOSSARY

Term	Definition
Acute Condition	A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.
At-Risk Member	A Covered California Member who is: 1. in the middle of acute treatment or those who would otherwise qualify for Continuity of Care under California law; 2. in case management programs; 3. in disease management programs; or 4. on maintenance prescription drugs for a chronic condition.
Authorized Representative	An individual who is (1) the legal representative or otherwise legally able to act on behalf of a Member, as the law of the State in which the Member resides may allow; (e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity), or (2) appointed in writing by a competent Member to act on behalf of the member for a limited purpose (e.g., to represent the member in DHCS State Fair Hearings, DMHC Independent Medical Reviews, filing Grievances and Appeals, claims adjudications). The DMHC Authorized Assistant Form may be used to appoint an authorized assistant to assist the Member with Independent Medical Review or complaint, provided a power of attorney for health care decisions or other legal document is submitted by an individual seeking to represent a Member who does not have legal capacity to appoint an authorized assistant.
Continuity of Care	Services provided to a Member rendered by a nonparticipating Provider with whom the Member has a pre-existing Provider relationship.
High-Risk Member	An at-risk Member who is: 1. Pregnant 2. Undergoing active cancer treatment 3. Scheduled for a planned procedure or surgery, or 4. Undergoing medication assisted treatment for substance use disorders.
Hospital	A hospital as defined in subdivision (a), (b), or (f) of Health & Safety Code §1250.
Individual Provider	A person who is a licentiate, as defined in Section 805 of the Business and Professions Code, or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code).
Maternal Mental Health Condition	A mental health condition that can impact a woman during Pregnancy, peri or postpartum, or that arises during Pregnancy, in the peri or postpartum period, up to one year after delivery
Nonparticipating Provider	A provider who is not contracted with CalOptima Health or its Health Networks to provide services under the Member's CalOptima Health plan contract.

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Term	Definition
Pregnancy	The three (3) trimesters of Pregnancy and the immediate postpartum period.
Prior Authorization	A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services.
Provider Group	A group of physicians or other Health Care Professionals that is clinically integrated, financially integrated, or that contract together to provide care to patients in a coordinated manner.
Serious Chronic Condition	A medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.
Terminal Illness	A Terminal Illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less.

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Policy:	CC.1501
Title:	**Continuity of Care During Health Network or Provider Termination**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/*
Effective Date:	01/01/2027
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☒ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy establishes coverage and Continuity of Care guidelines for a Member who is involuntarily required to change a Health Network or Provider.

II. POLICY

A. CalOptima Health shall furnish Covered Services in a manner providing Continuity of Care and ready referral of patients to other Providers at times as may be appropriate consistent with good professional practice.

B. CalOptima Health shall include on its Internet Web site a detailed description of, or a link to, how a Member may request Continuity of Care.

C. CalOptima Health or a Health Network may require a Member to change his or her Health Network or Provider involuntarily due to special circumstances, including, but not limited to, suspensions, termination, or non-renewal of a Health Network or Provider's contract with CalOptima Health or a Health Network, including termination, suspensions, and exclusions from federal health care programs such as Medi-Cal or Medicare.

1. CalOptima Health or a Health Network shall ensure the safe transition to a new Provider for services as necessary and in accordance with this policy, ensuring reasonable consideration is given to the potential clinical effect on a Member's treatment caused by a change of Provider.

D. CalOptima Health and its Health Networks shall provide written information on how to request Continuity of Care to their contracting Providers and Provider Groups.

E. CalOptima Health or a Health Network shall provide training to call center staff who come into regular contact with Members about Continuity of Care requests and protections.

F. Health Networks shall notify CalOptima Health of Provider terminations, in accordance with CalOptima Health Policies DD.2012: Member Notification of Change in Location or Availability of Providers of Covered Services, EE.1101: Additions, Changes, and Terminations to CalOptima Health Provider Information, and CC.1300: Block Transfers.

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G. CalOptima Health shall notify an Affected Member of the new Health Network assignment and the option to select a new Health Network in accordance with CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process.

H. A Receiving Health Network shall assume full responsibility for an Affected Member's care upon the Affected Member's effective date with the Receiving Health Network when the Member is involuntarily required to change Health Networks.

I. In the event of a change of Health Network under Section III.B of this policy, a Receiving Health Network shall ensure the provision of Covered Services to an Affected Member without disruption or delay, in accordance with this policy.

J. In the event that a Member is required to change Health Networks, CalOptima Health and the Receiving Health Network shall collaborate to coordinate the provision of current and future Covered Services for the Affected Member.

K. To ensure that inappropriate disruptions or delays in Covered Services do not occur during an Affected Member's transition to a Receiving Health Network, CalOptima Health and the Receiving Health Network shall make Continuity of Care decisions in accordance with the guidelines set forth in this policy and based on the potential best medical outcome for the Affected Member.

III. PROCEDURE

A. Identification of an Affected Member and the Affected Member's Needs during a Health Network Termination

1. CalOptima Health shall work in collaboration with the terminating Health Network to ensure identification of an Affected Member who is involuntarily required to change Health Networks and identify those Members who are eligible to request Continuity of Care for Covered Services within a Health Network.

2. CalOptima Health shall provide a Receiving Health Network with information about an Affected Member's Continuity of Care needs as the information becomes available.

3. A Receiving Health Network shall evaluate an Affected Member's need for Covered Services and shall authorize appropriate Covered Services for the Affected Member in a timely manner in order to not delay or interrupt the Affected Member's active treatment plan, in accordance with this policy.

B. Notice to Affected Members of a Health Network Termination

1. CalOptima Health shall send written notice of a Health Network termination to the Affected Members in accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers of Covered Services or CC.1300: Block Transfers.

C. In the event that the guidelines set forth in this policy do not address an Affected Member's particular Continuity of Care circumstance or need during the Affected Member's transition from a Health Network, CalOptima Health's Chief Medical Officer or his or her Designee shall render final determination of a Health Network's decision regarding the authorization of Covered Services, ensuring that reasonable consideration is given to the potential clinical effect on a Member's

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treatment caused by a change of Provider.

D. To ensure the Continuity of Care for an Affected Member, a Receiving Health Network shall coordinate the Affected Member's Covered Services and the payment of Covered Services to a Provider when the prior Health Network authorized the Affected Member's care with the existing Provider and there is an existing course of treatment. The Receiving Health Network shall reimburse a Non-Contracted Provider in accordance with this policy.

E. A Receiving Health Network shall notify an Affected Member of its decision to approve, modify, delay, or deny a request for authorization of Continuity of Care, in accordance with the guidelines set forth in CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

F. CalOptima Health or a Health Network shall notify an Affected Member of a Provider termination, in accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers of Covered Services or CC.1300: Block Transfers, as applicable.

G. Authorization for Continuity of Care

1. Upon identification of a Member with a Continuity-of-Care need or upon receipt of a Member's request for Continuity of Care, CalOptima Health or a Health Network shall collect the Affected Member's Medical Records and other information necessary to review the request for Continuity of Care.

2. When a request for Continuity of Care is made, CalOptima Health or a Health Network shall initiate the review process within five (5) business days after receipt of the request.

    a. The Continuity of Care process begins when CalOptima Health or a Health Network starts to determine if there is a pre-existing relationship and enters into an agreement with the Provider.

3. CalOptima Health or a Health Network shall give reasonable consideration to the potential clinical effects on an Affected Member's treatment caused by a change in Provider, or, and shall consider the following criteria in adjudicating a request for Continuity of Care:

    a. Determine if the Affected Member has one of the conditions described in Section III.G.6. of this policy;

    b. Determine if the Affected Member is in active treatment for such condition;

    c. Determine if the Affected Member can safely transition to a participating Provider, or practitioner, instead of continuing care with the Nonparticipating Provider, or practitioner; and

    d. Determine if transitioning the Affected Member to a new Provider, or practitioner, would compromise the treatment plan, or worsen the condition of the Affected Member.

4. CalOptima Health or a Health Network shall make a decision on the request for Continuity of Care within the following time frames, as applicable:

    a. Thirty (30) calendar days from the date the request received; or

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b. Fifteen (15) calendar days if the Member's medical condition requires more immediate attention; or

c. Three (3) calendar days if there is risk of harm to the Member.

5. CalOptima Health or a Health Network shall notify an Affected Member of its decision to approve, or deny, a request for Continuity of Care within seven (7) calendar days of the decision and include the following:

   a. Statement of decision;

   b. Duration of the Continuity-of-Care arrangement;

   c. The process that will occur to transition the Member's care at the end of the Continuity of Care period; and

   d. The Member's right to choose a different in-network Provider.

6. CalOptima or its Health Network shall, at the request of a Member, provide for the completion of Covered Services to a Member by a terminated Provider if, at the time of the Provider's contract termination, the Member was receiving services for one of the conditions, and for the durations, as follows:

Condition, as defined	**Completion of Covered Services shall be provided**
Acute Condition, including mental health conditions	For the duration of the Acute Condition, not to exceed 12 months from the contract termination date
Serious Chronic Condition, including mental health conditions	For a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by CalOptima Health in consultation with the Member and the terminated Provider or Nonparticipating Provider and consistent with good professional practice, and not to exceed 12 months from the contract termination date
A Pregnancy	For the duration of the Pregnancy
A Maternal Mental Health Condition, if written documentation of a Maternal Mental Health Diagnosis from the Member's treating health care Provider is presented	Not to exceed 12 months from the diagnosis or from the end of Pregnancy, whichever occurs later
A Terminal Illness	For the duration of the Terminal Illness, which may exceed 12 months from the Provider contract termination date
Care of a newborn child between birth and age 36 months	Not to exceed 12 months from the contract termination date
Performance of a surgery or other procedure that is authorized by CalOptima Health as part of a documented course of treatment and has been	To occur within 180 days of the contract's termination date

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Condition, as defined	Completion of Covered Services shall be provided
recommended and documented by the Provider	

7. If CalOptima Health or a Health Network denies Continuity of Care for an Affected Member, CalOptima Health or the Health Network shall request an Affected Member's medical records from the Provider and shall coordinate the transfer of such medical records and the transition plan to the contracting Provider, or practitioner, to whom the Affected Member is transitioning. CalOptima Health or the Health Network shall ensure that there is no delay in the Affected Member's care.

H. A Continuity of Care request is considered completed when:

1. The Member is informed of their right to continued access or if CalOptima Health or a Health Network and the Nonparticipating Provider are unable to agree to terms;

2. CalOptima Health or a Health Network has documented quality of care issues with the Provider; or;

3. CalOptima Health or a Health Network makes a good faith effort to contact the Provider and the Provider is non-responsive for thirty (30) calendar days.

I. If CalOptima Health or the Health Network are unable to reach an agreement with the Nonparticipating Provider on terms or a reimbursement rate, or there is documented quality of care issues with the Provider, CalOptima Health, or a Health Network shall offer the Member an in-network Provider alternative.

J. CalOptima Health, or the Health Network shall notify the Member thirty (30) calendar days before the end of the Continuity-of-Care period about the process that will occur to transition the Member's care at the end of the Continuity-of-Care period. This process shall include engaging with the Member and Provider before the end of the Continuity-of-Care period to ensure continuity of services to the new Provider.

K. Continuity of Care for Durable Medical Equipment (DME) and medical supply providers:

1. CalOptima Health or a Health Network shall allow a Member with existing DME rental to keep their existing rental equipment as follows:

a. After ninety (90) days and until the Member can be reassessed;

b. If Medically Necessary, authorize a new rental; and

c. Have an in-network Provider deliver the Medically Necessary rental.

2. CalOptima Health or a Health Network shall allow a Member with an open authorization to receive medical supplies to keep their existing Provider as follows:

a. For ninety (90) days and until Member is reassessed;

b. If Medically Necessary, authorize supplies; and

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c. Have an in-network Provider deliver the Medically Necessary supplies.

L. Provision of Covered Services

1. CalOptima Health or a Health Network shall allow a Member to change to an in-network Provider at any time regardless of whether or not a Continuity-of-Care relationship has been established.

2. A terminated Provider whose services are continued beyond the contract termination date pursuant to this policy shall agree in writing to be subject to the same contractual terms and conditions that were imposed upon the Provider before termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated Provider does not agree to comply or does not comply with these contractual terms and conditions, CalOptima Health or its Health Network shall not continue the Provider's services beyond the contract termination date.

3. Unless otherwise agreed upon by the terminated Provider and CalOptima Health or its Health Network, the services rendered pursuant to this policy shall be compensated at rates and methods of payment similar to those used by CalOptima Health or its Health Network for currently contracting Providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated Provider. Neither CalOptima Health nor its Health Network shall continue the services of a terminated Provider if the Provider does not accept the payment rates provided for in this paragraph.

4. If a terminated Provider or practitioner does not agree to comply, or does not comply, with the contractual terms and conditions as described in Section III.L.2. of this policy, or if such Provider or practitioner does not accept the contract rate offered by a Health Network as described in Section III.L.3 of this policy, the Health Network shall notify CalOptima Health of the Provider's or practitioner's refusal prior to transitioning an Affected Member's care.

5. Neither CalOptima Health nor the Noncontracting Provider shall require a CalOptima Health Member to pay a copayment, deductible, or other cost-sharing component during the period of completion of Covered Services, other than what would be required if the Member were receiving care from a Provider currently contracting with or employed by CalOptima Health or its Health Networks.

6. CalOptima Health or its Health Network shall not provide for completion of Covered Services by a Provider whose contract with CalOptima Health or its Health Network has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in Business and Professions Code § 805(a)(6), or fraud, or other criminal activity.

7. CalOptima Health or its Health Network shall not cover services or provide benefits that are not otherwise covered under the terms and conditions of the Member's CalOptima Health contract.

M. Members shall be notified of a denied Continuity-of-Care decision, in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

N. If the Member does not agree with the result of the Continuity-of-Care decision, they retains the right to pursue a grievance, in accordance with CalOptima Health Policy CC.1201: Member Grievance.

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O. Health Networks shall report all requests and outcomes from former Medi-Cal Fee For Service and former Covered California enrollees asking to remain with their Primary Care Provider, or specialty care Providers, to CalOptima Health's Health Network Relations Department in a format and at a frequency prescribed by CalOptima Health.

P. CalOptima Health's Customer Service and Case Management Departments shall compile and maintain a log of Continuity-of-Care requests made directly to, and decisions made by, CalOptima Health.

Q. CalOptima Health's Customer Service, Health Network Relations, and Case Management Departments shall submit their Continuity-of-Care reports to CalOptima Health's Regulatory Affairs & Compliance Department.

R. CalOptima Health may impose Sanctions on a Health Network, including, and without limitation, financial penalties or termination, in accordance with CalOptima Health Policy HH.2002: Sanctions, when the Health Network fails to comply with the requirements of this policy.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Health and Safety Code §§ 1367(d), 1373.95, 1373.96, 1374.73
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Contract with the Covered California
D. CalOptima Health Policy CC.1201: Member Grievance
E. CalOptima Health Policy CC.1500: Continuity of Care for Members Transitioning into CalOptima Health Services
F. CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process
G. CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers of Covered Services
H. CalOptima Health Policy EE.1101: Additions, Changes, and Terminations to CalOptima Health Provider Information
I. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
J. CalOptima Health Policy HH.2002: Sanctions
K. Title 28, California Code of Regulations §§ 1300.67.1(c) through (e), 1300.80(b)(4)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

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Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1501	Continuity of Care During Health Network or Provider Termination	Covered California

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IX. GLOSSARY

Term	Definition
Acute Condition	medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.
Affected Member	For purposes of this policy, a Member who is involuntarily transitioning between Health Networks or Providers due to circumstances that include but are not limited to the termination or non-renewal of a Health Network Contract.
Continuity of Care	Services provided to a Member rendered by an out-of-network Provider with whom the Member has a pre-existing Provider relationship.
Covered Services	Health care services that are covered benefits under CalOptima Health's contract with Covered California as further described in the Evidence of Coverage and supporting documents.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Durable Medical Equipment (DME)	Medically Necessary medical equipment, as defined by Title 22, California Code of Regulations § 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.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a health maintenance organization (HMO), subcontractor, or first tier entity, that contracts with CalOptima Health to provide Covered Services to Members.
Maternal Mental Health Condition	A mental health condition that can impact a woman during Pregnancy, peri or postpartum, or that arises during Pregnancy, in the peri or postpartum period, up to one year after delivery.
Medically Necessary or Medical Necessity	Health care and related services and supplies provided to a Member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care Provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results. For treatment of a mental health or substance use disorder, Medical Necessity shall include: A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) in accordance with the generally accepted standards of mental health and substance use disorder care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; (iii) not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care Provider, as required by HSC §1374.72 (a)(3)(A).
Member	An individual enrolled in a CalOptima Health program.
Nonparticipating Provider	A Provider who is not contracted with CalOptima Health to provide services under the Member's CalOptima Health plan contract.
Pregnancy	The three (3) trimesters of Pregnancy and the immediate postpartum period.

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Term	Definition
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a primary care physician or non-physician medical practitioner.
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services.
Provider Group	A group of physicians or other Health Care Professionals that is clinically integrated, financially integrated, or that contract together to provide care to patients in a coordinated manner.
Receiving Health Network	A Health Network to which a Member is transitioning.
Sanctions	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a first tier, downstream, or related entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health programs according to CalOptima Health Policy HH.2002: Sanctions.
Serious Chronic Condition	A medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contact

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

Recommended Action

Approve New CalOptima Health Policy CC.1100: Oversight of Administrative Vendors, effective January 1, 2027.

Background

On August 1, 2024, the CalOptima Health Board of Directors (Board) authorized the Chief Executive Officer (CEO) to convene a stakeholder steering committee composed of key external partners and providers to discuss considerations for potential participation in Covered California. CalOptima Health leadership and staff convened the Covered California Stakeholder Steering Committee, which has met on nine separate occasions. On October 3, 2024, the Board directed the CEO to request the Orange County Board of Supervisors (BOS) to amend CalOptima Health's governing ordinance to remove the prohibition on participation in Covered California. On January 14, 2025, the BOS unanimously voted to amend the ordinance to allow CalOptima Health's participation in Covered California. On December 5, 2024, the Board approved actions related to Covered California consulting support contracts and associated funding.

CalOptima Health must obtain approval to operate a Covered California product under its Knox-Keene Act license from the California Department of Managed Health Care (DMHC). Obtaining a Knox-Keene Act license or expanding an existing license is a regulatory filing process that all plans must comply with to offer an individual market health plan. While CalOptima Health is currently licensed with DMHC for the OneCare Medicare product, CalOptima Health must submit a filing to expand its current Knox-Keene Act license to participate in the individual market. As a first step in this process, CalOptima Health participated in a pre-filing conference with DMHC on February 25, 2025.

Discussion

The DMHC filing process is a multi-phased process that CalOptima Health must complete by early 2026 to obtain the proper approvals to operate an individual market health plan. The process requires the submission of at least 89 supporting exhibits that demonstrate compliance with the requirements of the Knox-Keene Act.

Several of the documents that must be submitted to DMHC are policies and procedures that demonstrate compliance with statutory and regulatory requirements. Staff has evaluated the policies and procedures

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that are needed to demonstrate compliance. In the area of vendor oversight, staff recommends approval of one new policy.

Policy & Procedure Summary – Oversight of Administrative Vendors

The DMHC license filing requires submission of a policy and procedure detailing how the plan oversees and monitors each of its administrative services vendors. Staff proposes new Policy CC.1100: Oversight of Administrative Vendors to demonstrate compliance with this requirement.

CalOptima Health must submit certain Administrative Service Agreements (ASAs), including amendments, to the DMHC for review and approval. When submitting an ASA to DMHC, CalOptima Health must comply with applicable requirements of the DMHC ASA checklist, which includes providing DMHC with:

- A narrative description of the information included in the filing;
- Copies of the ASA and/or amendments;
- Copies of the compensation terms; and
- Monitoring and oversight arrangements.

Policy CC.1100: Oversight of Administrative Vendors describes the scope and mechanisms by which CalOptima Health will conduct monitoring activities of vendors that perform administrative services under an ASA. The policy outlines the process for performance monitoring, financial oversight, issue resolution, and contingency planning, when applicable.

This new policy demonstrates compliance with the following statutory requirements and DMHC guidance:

- California Code of Regulations, Title 28 §§ 1300.51(d)(N), 1300.67.3(a), and 1300.85.1;
- Code of Federal Regulations § 156.340; and
- DMHC All Plan Letter 18-005: Administrative Services Agreement (ASA) Checklist.

Staff seeks Board approval of the attached new policy, effective January 1, 2027.

Fiscal Impact

The recommended action is operational in nature and has no anticipated fiscal impact.

Rationale for Recommendation

Approval of CalOptima Health Policy CC.1100: Oversight of Administrative Vendors will support CalOptima Health's application to expand its Knox-Keene Act license to operate an individual market plan.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Attachment 1: CalOptima Health Policy CC.1100: Oversight of Administrative Vendors

/s/ Michael Hunn *05/29/2025*
Authorized Signature **Date**

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Policy:	CC.1100
Title:	**Monitoring and Oversight of Administrative Vendors**
Department:	Delegation Oversight
Section:	N/A
CEO Approval:	*/s/*
Effective Date:	01/01/2027
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☒ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy describes the scope, processes, and mechanisms by which CalOptima Health conducts monitoring activities of Vendors that perform administrative services under administrative services agreements (ASAs) subject to the Knox-Keene Act and regulated by the Department of Managed Health Care (DMHC).

II. POLICY

A. The Chief Financial Officer (CFO), with the assistance of the Vendor Management department, shall oversee the procurement of Vendors in accordance with CalOptima Health Policy GA.5002: Purchasing.

B. The Vendor Management department will track whether a Vendor agreement is classified as an ASA and whether the Vendor is also classified as a Delegated Entity based on determinations made by the Office of Compliance and the Delegation Oversight departments.

C. CalOptima Health internal business units that hold ASA contracts with a vendor shall conduct annual performance assessments of Vendors that perform administrative services contracted through CalOptima Health's ASA to ensure compliance with contractual standards and requirements.

D. The Delegation Oversight department will conduct annual audits of Vendors classified as Delegated Entities and more frequent visits, if necessary, based on the circumstances and Vendor's performance under the ASA.

E. Results from Delegation Oversight annual audits of delegated Vendors will be reported to the Delegation Oversight Committee (DOC).

F. The Vendor Management department will conduct the following activities:

1. Determine each Vendor's ability to meet state and federal laws and CalOptima Health's business and contractual requirements with input from CalOptima Health business units.

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2. Collect information confirming that the annual review activities of Vendors are conducted by CalOptima Health business units and retain the information for a minimum of ten (10) years from the final date of a state or federal program contract period or from completion of any audit or investigation, whichever is later.

3. Ensure Vendor contracts include a provision requiring that Vendors retain and make available upon request from state and federal authorities, any documents, records, contracts, financial statements for inspection and audit related to ensuring compliance under the agreement for a minimum of ten (10) years from the final date of the agreement period.

G. CalOptima Health will notify Covered California and the DMHC in advance of assignment or delegation of duties impacting the Covered California line of business. This notice requirement applies to new assignment and delegation as well as changes or amendments to existing assignment or delegation for the following:

1. Enrollment and Eligibility;

2. Customer Service Call Center;

3. Managed Behavioral Health Organizations (MBHOs) or Behavioral Health Vendor;

4. Third-Party Administrator for Dental Providers;

5. Third-Party Administrator for Provider Contracts; or

6. Third-Party Administrator for Claims Administration.

H. Failure to comply with applicable statutory, regulatory, contractual, CalOptima Health policy, or other requirements may subject Vendors to Corrective Action Plans (CAPs), Sanctions, and/or contract termination in accordance with CalOptima Health Policies HH.2002: Sanctions and HH.2005: Corrective Action Plan.

I. If CalOptima Health identifies in the long-term any Vendor performance or compliance issues that persist, CalOptima Health may add another Vendor or additional staff to ensure there is no interruption or reduction in services to CalOptima Health or its Members and shall terminate the Vendor's ability to provide services.

III. PROCEDURE

A. Responsible Personnel

1. The Vendor Management department is responsible for maintaining a tracking system of all Vendors. The tracking system captures:

a. Vendors classified as ASA Vendors, as determined by the Office of Compliance and the business unit.

b. Vendors classified as Delegated Entities, as determined by the Delegation Oversight department and the business unit.

c. Confirmation of annual assessments completed by the business units for non-Delegated ASA Vendors.

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2. Business units are responsible for conducting monitoring and oversight of ASA Vendors that are not classified as Delegated Entities.

3. The Delegation Oversight department is responsible for conducting annual audits of Vendors classified as Delegated Entities.

    a. The Director of the Delegation Oversight Department shall serve as the chair of the DOC in accordance with CalOptima Health Policy HH.4001: Delegation Oversight Committee.

    b. Each member of the DOC is a voting member in accordance with CalOptima Health Policy HH.4001: Delegation Oversight Committee. Voting members may appoint a Designee, when deemed appropriate. The Designee may serve as a subject matter expert at the DOC meeting; however, the Designee will not have voting rights unless approved in advance by the chair.

B. Performance Monitoring

1. Pre-Contracting Assessment Process

    a. Prior to granting an ASA to a proposed Vendor, CalOptima Health shall conduct a pre-contracting assessment to determine the Vendor's ability to implement proposed Vendor activities.

    b. Prior to delegating a health plan function to a Delegated Entity, CalOptima Health shall conduct a Pre-Delegation Readiness Assessment in accordance with CalOptima Health Policy GG.1619: Delegation Oversight to determine the Delegated Entity's ability to accept delegation from CalOptima Health.

2. Routine Audits and Monitoring/Performance Monitoring

    a. At least annually, each CalOptima Health business unit overseeing a non-Delegate ASA shall perform an annual assessment to evaluate, at a minimum, the Vendor's performance of contracted activities and responsibilities, as evidenced by the ASA, and compliance with applicable legal requirements and CalOptima Health policies and procedures. The annual assessment will use a standardized annual assessment tool. The tool assesses operational performance by the business unit and solicits feedback from business areas (compliance, FWA, appeals and grievances, QI) to identify and assess performance by the vendor for the year.

    b. For ASAs with Vendors classified as Delegated Entities, the Delegation Oversight department shall schedule an audit with the Vendor in accordance with CalOptima Health Policy GG.1619: Delegation Oversight. Oversight audits are required annually and shall be conducted as desktop, on-site, and/or webinar audits. The Delegation Oversight Department may determine to conduct more frequent audits and/or targeted audits.

        i. Each audit will evaluate, at a minimum, the Vendor's performance of delegated activities and responsibilities required by the Delegation Agreement, and compliance with applicable legal requirements and CalOptima Health policies and procedures.

        ii. If the Delegated Entity receives a score of less than 95% on any audit element of the Delegation standards, the Delegated Entity shall be required to develop a CAP.

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iii. The auditor shall have ultimate responsibility for the CAP remediation and for monitoring and reporting the CAP to the DOC. The audit manager shall report the findings of the audit, the CAPs, if any, and the timeline for CAP remediation to the DOC.

iv. Annual audit findings of ASA with Delegated Entities will be presented to the DOC.

v. Focused audits of Delegated Entities may be conducted as needed and at the discretion of CalOptima Health for the following situations:

a) Repeated instances of non-compliance;

b) At the direction of Plan's Senior Leadership Team; or

c) At the direction of regulatory or other law enforcement agencies.

C. Compliance Monitoring

1. If CalOptima Health or any authorized authority determines there is a reasonable possibility of fraud or similar risk, CalOptima Health or the authority may inspect, evaluate, and audit the Vendor at any time.

D. Financial Oversight

1. If CalOptima Health or any authorized authority determines there is a reasonable possibility of an issue impacting a Vendor's financial viability, CalOptima Health or the authority may inspect, evaluate, and audit the Vendor at any time.

E. Issue Resolution and Corrective Action

1. Corrective Action Plan

a. If any area of deficiency or non-compliance is identified through any internal or external sources, including but not limited to, Member or provider complaints, Readiness Assessment reviews, regulatory audits, regular reports, oversight reviews, and ongoing monitoring, CalOptima Health may require an ASA Vendor to respond to a CAP and submit a CAP response.

b. An ASA Vendor shall comply with CAP requirements set forth in CalOptima Health Policy HH.2005: Corrective Action Plan.

c. In accordance with CalOptima Health Policy HH.2002: Sanctions, CalOptima Health may impose progressive disciplinary actions on an ASA Vendor with consistent performance issues or findings regarding significant compliance issues.

F. Contingency Planning and Function Recovery

1. The ASA may be revoked/terminated in instances where CalOptima Health or a regulatory agency determines that the Vendor has not performed satisfactorily, including, but not limited to, failing to implement a CAP or quality improvement plan and or upon determination of fraud.

2. Vendor Management and/or CalOptima Health business units overseeing an ASA with a Vendor may make a determination for complete or partial revocation of an ASA with a Vendor.

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3. For ASAs with Vendors classified as Delegated Entities, the Delegation Oversight Department may recommend that the DOC approve a complete or partial revocation of an ASA with a Vendor.

4. Upon revocation or termination of an ASA, contracted services may be conducted by CalOptima Health or will be reassigned to another party.

5. If CalOptima Health terminates activities from the ASA Vendor, Vendor Management (or Delegation Oversight in the case of Delegated Entities) shall ensure the following steps are taken:

   a. Provide the Vendor with a thirty (30) calendar day written notice of CalOptima Health's intent to terminate (unless the circumstances warrant a shorter time frame for termination);

   b. Inform Members and providers of the termination, and provide instructions for continued services;

   c. Adjust the ASA Vendor's payments as appropriate to the ASA Vendor's activity; and

   d. Prepare appropriate CalOptima Health departments to provide the formerly contracted activities.

6. The Vendor shall cooperate with CalOptima Health to ensure smooth transition and continuous care for Members during the transition period.

IV. ATTACHMENT(S)

Not applicable

V. REFERENCE(S)

A. CalOptima Health Contract with Covered California
B. CalOptima Health Policy GA.5002: Purchasing
C. CalOptima Health Policy GG.1619: Delegation Oversight
D. CalOptima Health Policy HH.2002: Sanctions
E. CalOptima Health Policy HH.2005: Corrective Action Plan
F. CalOptima Health Policy HH.4001: Delegation Oversight Committee
G. Code of Federal Regulations § 156.340
H. Department of Managed Health Care (DMHC) All Plan Letter (APL) 18-005: Administrative Services Agreement
I. Title 28, California Code of Regulations § 1300.51(d)(N)
J. Title 28, California Code of Regulations § 1300.67.3(a)
K. Title 28, California Code of Regulations § 1300.85.1

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1100	Monitoring and Oversight of Administrative Vendors	Covered California

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IX. GLOSSARY

Term	Definition
Administrative Service Agreement (ASA)	A written contract between CalOptima Health and a Vendor for the provision of one or more administrative services that support CalOptima Health's operations and obligations as a health care service plan.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The committee is composed of Senior Management staff and chaired by the Chief Compliance Officer or his/her designee.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Covered California, Department of Managed Health Care (DMHC), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators in accordance with HH.2005: Corrective Action Plan.
Delegation Oversight Committee (DOC)	A subcommittee of the Compliance Committee chaired by the Director of Delegation Oversight to oversee CalOptima Health's delegated functions according to CalOptima Health Policy HH.4001: Delegation Oversight Committee.
Delegated Entity	For purposes of this policy, a delegated entity is contracted with CalOptima Health and is delegated to make decisions on CalOptima's behalf, involving one or more of the following functions: utilization management, quality improvement, enrollment, or disenrollment, credentialing, claims administration, processing and coverage adjudication, appeals and grievances, licensing and credentialing, pharmacy benefit management, outbound enrollment verification, provider network participation, administration and tracking of enrollees' drug benefits, or health care services.
Readiness Assessment	An assessment conducted by a Delegation Oversight prior to the effective date of a Delegated Entity's contract with CalOptima Health of the Delegated Entity's or contracted entity's compliance with all or a specified number of the regulatory requirements applicable to delegated functional areas as determined by CalOptima Health according to CalOptima Health Policy GG.1619: Delegation Oversight.
Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a first tier, downstream, or related entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health programs according to CalOptima Health Policy HH.2002: Sanctions.

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Term	Definition
Vendor	External individual or organization that has contracted with CalOptima Health to provide administrative services. For the purposes of this policy, a Vendor refers specifically to those entities that perform administrative functions on behalf of CalOptima Health under an Administrative Services Agreement (ASA).

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contacts

Yunkyung Kim, Chief Operating Officer, 714-246-8408
Ladan Khamseh, Executive Director, Operations, (714) 246-8866

Recommended Actions

Approve new policies and procedures related to Covered California, effective January 1, 2027:

1. Policy CC.1200: Member Appeals;
2. Policy CC.1201: Member Grievances;
3. Policy CC.1001: Claims Processing for Covered Services; and
4. Policy CC.1300: Block Transfer.

Background

On August 1, 2024, the CalOptima Health Board of Directors (Board) authorized the Chief Executive Officer (CEO) to convene a stakeholder steering committee composed of key external partners and providers to discuss considerations for potential participation in Covered California. CalOptima Health leadership and staff convened the Covered California Stakeholder Steering Committee, which has met on nine separate occasions. On October 3, 2024, the Board directed the CEO to request the Orange County Board of Supervisors (BOS) to amend CalOptima Health's governing ordinance to remove the prohibition on participation in Covered California. On January 14, 2025, the BOS unanimously voted to approve to amend the ordinance to allow CalOptima Health's participation in Covered California. On December 5, 2024, the Board approved actions related to Covered California consulting support contracts and associated funding.

CalOptima Health must obtain approval to operate a Covered California product under its Knox-Keene Act license from the California Department of Managed Health Care (DMHC). Obtaining a Knox-Keene Act license or expanding an existing license is a regulatory filing process that all plans must comply with to offer an individual market health plan. While CalOptima Health is currently licensed with DMHC for the OneCare Medicare product, CalOptima Health must submit a filing to expand its current Knox-Keene Act license. As a first step in this process, CalOptima Health participated in a pre-filing conference with DMHC on February 25, 2025.

Discussion

The DMHC filing process is a multi-phased process that CalOptima Health must complete by early 2026 to obtain the proper approvals to operate an individual market health plan. The process requires the submission of at least 89 supporting exhibits that demonstrate compliance with the requirements of the Knox-Keene Act.

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Several of the documents that must be submitted to DMHC are policies and procedures that demonstrate compliance with statutory and regulatory requirements. Staff has evaluated the policies and procedures that are needed to demonstrate compliance. In the area of core operations, staff recommends approval of four new policies and procedures to demonstrate compliance with grievances and appeals, claims, and member block transfer requirements. These new policies are outlined below.

Policies & Procedures Summary – Grievances and Appeals

The DMHC filing requires submission of policies and procedures related to enrollee grievance procedures, including:

- Description of the enrollee grievance system;
- Processes related to receiving and handling grievances within established timeframes;
- Requirements for member forms; and
- Requirements for maintenance of records.

Staff recommend the approval of two new policies to demonstrate compliance with these requirements:

- Policy CC.1200: Member Appeals.
- Policy CC.1201: Member Grievances.

These new policies demonstrate compliance with DMHC requirements regarding:

- Grievances submitted by a member, provider, or a member's authorized representative;
- Standard and expedited, pre-service and post-service appeals; and
- Member appeals of adverse benefit determinations.

These policies also include requirements related to the DMHC grievance and appeal process, including timeframes and requirements for exempt, expedited, and standard grievances and expedited and standard appeals, criteria for Independent Medical Reviews, members' rights to file grievances for CalOptima's failure to provide trans-inclusive care, and annual reporting requirements to DMHC.

To meet the grievance and appeals requirements, staff drafted Policy CC.1201: Member Grievances to establish processes by which CalOptima Health addresses and resolves grievances from a member, a provider, or authorized representative acting on behalf of a member and with the member's written consent.

Policy CC.1200: Member Appeals describes the process by which CalOptima Health reviews, addresses, and resolves standard and expedited, pre-service, and post-service member appeals of adverse benefit determinations. This also includes delay, modification, or denial of services based on medical necessity or determinations that requested services are not covered benefits. Additionally, both policies include member notification, record retention, and reporting to external and internal parties, when applicable.

These two new policies demonstrate compliance with the following statutory requirements and DMHC guidance:

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- California Code of Regulations, Title 28 §§ 1300.68, 1300.85 and 1300.85.1;
- California Health & Safety Code §§ 1366, 1367, 1368, 1370, 1371, 1374;
- Covered California Qualified Health Plan Contract;
- DMHC All-Plan-Letter (APL) 24-018: Compliance with Senate Bill 923;
- DMHC APL 22-021: Quarterly Grievance Report;
- DMHC APL 24-018: Compliance with Senate Bill 923;
- DMHC APL: Quarterly Grievance Report; and
- Title 45 of the Code of Federal Regulations.

Staff seeks Board approval of the attached new policies, effective January 1, 2027.

Policies & Procedures Summary – Claims Processing

The DMHC filing requires submission of policies and procedures covering the referral process, including follow-up on referrals, turnaround times, and payment for non-contracted providers. To meet this requirement, staff proposes new policy CC.1001: Claims Processing for Covered Services.

This new policy is developed to demonstrate compliance with DMHC requirements regarding timely processing of claims and payment for covered services in the commercial line of business.

To meet the claims processing requirements, staff drafted Policy CC.1001: Claims Processing for Covered Services to establish that CalOptima Health ensures timely processing of claims and payment for covered services for which CalOptima Health is financially responsible. Additionally, the policy has been updated to include DMHC balance billing requirements and payment for covered emergency services.

This policy demonstrates compliance with the following statutory requirements and DMHC guidance:

- California Code of Regulations, Title 28 §§ 1300.71, 1300.71.38;
- California Health & Safety Code §§ 1371-1371.39;
- Covered California Qualified Health Plan Contract;
- DMHC APL: 22-011: No Surprises Act (NSA) Guidance; and
- DMHC APL: 24-010: Coverage of Ground Ambulance Services Provided by a Noncontracted Provider.

Staff seeks Board approval of the attached new policy, effective January 1, 2027.

Policies & Procedures Summary – Block Transfer

The DMHC filing requires submission of policies and procedures covering the continuity, timeliness, and coordination of care between and among providers. To meet this requirement, staff proposes new Policy CC.1300: Block Transfer.

Statutory and regulatory requirements mandate that CalOptima Health notify and reassign members when a provider group or hospital contract termination triggers a block transfer filing by affecting 2,000

or more members. In addition, CalOptima Health is required to report to DMHC and Covered California on a block transfer filing.

To meet the block transfer requirements, staff drafted policy CC.1300: Block Transfer to describe the process by which CalOptima Health will notify and reassign members when impacted by a block transfer.

This new policy demonstrates compliance with the following statutory requirements and DMHC guidance:

- California Code of Regulations, Title 28 § 1300.67.1.3;
- California Health & Safety Code § 1373.65;
- Covered California Qualified Health Plan Contract;
- DMHC APL 19-013: Block Transfer Enrollee Transfer Notices; and
- DMHC APL 21-015: Office of Plan Monitoring – Block Transfer Portal Updates.

Staff seeks Board approval of the attached new policy, effective January 1, 2027.

Fiscal Impact
The recommended action is operational in nature. The anticipated costs will be included in future Covered California operating budgets.

Rationale for Recommendation
Approval of the four proposed new policies will support CalOptima Health's application to expand its Knox-Keene Act license to operate an individual market plan.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Attachment 1: CalOptima Health Policy CC.1200: Member Appeals
2. Attachment 2: CalOptima Health Policy CC.1201: Member Grievances
3. Attachment 3: CalOptima Health Policy CC.1001: Claims processing for Covered Services
4. Attachment 4: CalOptima Health Policy CC.1300: Block transfer

/s/ Michael Hunn *05/30/2025*
Authorized Signature **Date**

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Policy:	CC.1200
Title:	**Member Appeal Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2027
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☒ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy describes the process by which CalOptima Health reviews, addresses, and resolves standard and expedited, pre-service and post-service, Member Appeals of Adverse Benefit Determinations, which also includes the delay, modification, or denial of services based on Medical Necessity or determinations that requested services are not a covered benefit.

II. POLICY

A. CalOptima Health shall establish and maintain an Appeal Process pursuant to applicable statutory, regulatory, and contractual requirements.

B. A Member, or a Provider or Authorized Representative acting on behalf of the Member with the Member's written consent, has the right to file an Appeal in the timeframes set forth in this policy.

1. Members that are minors, incompetent, or incapacitated may have an Appeal requested on their behalf by a Relative, guardian, conservator, or other representative of the Member, as appropriate.

2. A Member shall not be financially responsible for the Independent Medical Review (IMR) application or processing fees of any kind.

C. CalOptima Health's Appeal Process shall address the receipt, handling, and disposition of a Member's Appeal, in accordance with applicable statutory, regulatory, and contractual requirements.

D. CalOptima Health shall assist a Member requiring assistance with filing an Appeal, including but not limited to a Member with Limited English Proficiency (LEP), disabilities, or cultural needs and in accordance with Section II.R.1.a-c. of this policy. CalOptima Health shall provide language assistance to Members, by CalOptima Health staff or language line interpreter services, for Threshold Languages to register and resolve Appeals.

E. CalOptima Health shall ensure prompt review and investigation of an Appeal. A Health Network may participate in the review and investigation of an Appeal.

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F. Subject to the provisions of this policy, CalOptima Health shall resolve a standard Appeal request within thirty (30) days after receipt of the Appeal, regardless of whether an oral Appeal is followed by a written Appeal.

G. Subject to the provisions of this policy, CalOptima Health shall resolve an Expedited Appeal no later than three (3) days after receipt of such Appeal request.

H. CalOptima Health shall refer all Appeals related to medical quality of care issues to the Quality Improvement (QI) Department for review by CalOptima Health's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process, in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.

I. For Appeals involving denial of therapy, medical service, or claim for urgent and Emergency Service based in whole or in part on a finding that the services were not Medically Necessary or were experimental or investigational, a Member has a right to submit the Appeal to the Department of Managed Health Care (DMHC) for an IMR.

1. CalOptima Health shall inform a Member during the Appeal Process of their right to request an IMR.

J. For Appeals involving the denial, to a Member with a Terminal Illness, for treatment, services, or supplies deemed experimental, as recommended by a participating plan Provider:

1. CalOptima Health shall provide the Member, within thirty (30) days, or within five (5) business days if the treating participating physician determines, after consultation with the CalOptima Health medical director or its Designee, based on standard medical practice, that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by CalOptima Health, would be materially reduced if not provided at the earliest possible date.

2. An opportunity to attend a conference, to review the information provided to the Member pursuant to CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

3. The conference shall be conducted by a CalOptima Health representative who has authority to determine the disposition of the Appeal.

4. CalOptima Health shall allow attendance, in person, at the conference, by a Member, a Designee of the Member, or both, or, if the Member is a minor or incompetent, the parent, guardian, or conservator of the Member, as appropriate.

K. Continuation of Services during Appeal Process

1. CalOptima Health or a Health Network shall also pay for disputed Covered Services if the Member received the disputed Covered Services while the Appeal or IMR was Pending.

L. Neither CalOptima Health, nor any of its Health Networks, or other Providers shall discriminate against a Member, or a Provider or Member's Authorized Representative on the grounds that they filed an Appeal, in accordance with CalOptima Health Policy HH.1104: Complaints of Discrimination.

M. The Member Appeal Process set forth in this policy is a separate process from the Member Grievance Process in CalOptima Health Policy CC.1201: Member Grievance. It is also separate

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from Provider processes in CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint.

N. Any changes to CalOptima Health's Grievance and Appeals policies and procedures shall be communicated to its Providers, subcontractors and downstream subcontractors in accordance with CalOptima Health Policy EE.1103: Provider Network Training.

O. A Provider may request an Appeal on their own behalf within one hundred eighty (180) days after receipt of the denial for authorization or payment for services already received by the Member, in accordance with CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint.

P. A Provider, with the Member's written consent, may request an Appeal on behalf of the Member for services rendered to that Member by submitting a written request to CalOptima Health within one hundred eighty (180) days from the date of the Notice of Adverse Benefit Determination/Notice of Action (NABD/NOA) from CalOptima Health or a Health Network, in accordance with the provisions of this policy.

Q. CalOptima Health shall give a Member, or a Provider, or Authorized Representative acting on behalf of the Member and with the Member's written consent, a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Appeal, evidence, testimony, facts, and law in support of the Appeal. CalOptima Health shall inform the Member, or a Provider or Authorized Representative, acting on behalf of the Member and with the Member's written consent, of the limited time available to present evidence sufficiently in advance of the Resolution timeframes, including for Expedited Appeal.

1. Resolution timeframes are as follows:

Appeal Request Type	Timeline Requirements	Extension
Standard Pre-Service	Thirty (30) calendar days	N/A
Standard Post Service	Thirty (30) calendar days	N/A
Expedited Pre-Service	Three (3) calendar days	N/A
Expedited Post Service	Three (3) calendar days	N/A

R. CalOptima Health and its Health Networks shall provide culturally and linguistically appropriate notices of the Appeals Process to Members, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services, including but not limited to, Acknowledgement Letters and Notices of Appeal Resolution.

1. CalOptima Health shall provide assistance to Members or a Member's Authorized Representative with disabilities, limited English proficiency, vision disorders, or other communicative impairments, when completing Appeal forms and other procedural steps, including but not limited to, providing all documents relied on for CalOptima Health's decision to the Member, in addition to the following services in accordance with CalOptima Health Policy DD.2002; Cultural and Linguistic Services:

   a. Alternative formats (as set forth in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services);

   b. Providing auxiliary aids and services upon request, such as interpreter services and a toll-free number with TTY/TDD and interpreter capability; and

   c. Assistance in the Appeal Process or provide translation of Appeal correspondence.

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S. A Member may be represented by anyone they choose during the Appeal Process, including an Authorized Representative. A Member, or the Member's Authorized Representative, may authorize a Provider to assist the Member in submitting the Grievance to DMHC and advocate on behalf of the Member.

T. The Member has the right to request an Appeal in the event CalOptima Health or a Health Network fails to issue an NABD/NOA within the required time frame, which shall be considered a denial and therefore constitutes an Adverse Benefit Determination.

U. CalOptima Health shall provide, upon request by the Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, before and during the Appeals Process, the opportunity to examine and/or obtain a copy of the Member's case file, including Medical Records, and any other relevant documents and records considered during the Appeals Process. CalOptima Health shall provide records at no cost.

V. CalOptima Health shall ensure that the person reviewing the Appeal was not involved in the initial determination and they are not the subordinate of any person involved in the initial determination.

W. CalOptima Health shall ensure that for Appeals, the person making the final decision for the proposed Resolution of an Appeal has not participated in any prior decisions related to the Appeal. Only qualified health care and licensed professionals with clinical expertise in treating a Member's condition or disease shall make the final determinations for all Appeals. Fiscal and administrative concerns shall not unduly influence the independence of the medical decision-making process.

X. All Medical Necessity Appeals are referred to the CMO or to their Designee who has the authority to require corrective action and is of the same or similar specialty, has clinical expertise in treating the Member's condition or disease, and is able to treat complications that may result from the service or procedure, if deciding on any of the following:

1. An Appeal of a denial based on lack of Medical Necessity or experimental/clinical investigation; and

2. Any Appeal involving clinical issues.

Y. Upon notice of a CalOptima Health decision to deny an authorization request, a Member, or a Provider or Authorized Representative acting on behalf of the Member, and with the Member's written consent, may request an Expedited Appeal in accordance with Section III.D. of this policy, when it is determined 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.

Z. CalOptima Health and a Health Network shall provide the CalOptima Health Grievance and Appeal system requirements to subcontractors at the time they enter into a subcontract, on an annual basis, and when CalOptima Health's relevant Grievance and Appeals policies and procedures are updated.

AA. In addition to any rights set forth in this policy, a Member or a Member's Authorized Representative shall also have the right to:

1. Request a standard or expedited IMR by DMHC.

2. CalOptima Health shall inform a Member of such IMR rights upon enrollment, annually, and in every Notice of Appeal Resolution (NAR) letter.

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3. If CalOptima Health fails to provide adequate notice to a Member with a visual impairment or other disabilities requiring the provision of written materials in alternative formats, within applicable federal or state timeframes, and in accordance with CalOptima Health Policy: DD.2002: Cultural and Linguistic Services, then the Member is deemed to have exhausted CalOptima Health's internal Appeal Process and may immediately request an IMR.

BB. Responsible staff

1. CalOptima Health's Chief Operating Officer shall have primary responsibility for:

   a. Maintenance of the Appeal Process;

   b. Review of the operations; and

   c. Review of any emerging patterns of Appeals in the formulation of policy changes and procedural improvements to CalOptima Health's administration of the program.

2. CalOptima Health's Director of Grievance and Appeals Resolution Services (GARS) shall have primary responsibility for the oversight of the Appeal Process.

III. PROCEDURE

A. Assistance to Members

1. CalOptima Health and a Health Network shall make Grievance and Appeal forms and procedures for filing an Appeal available to Providers and facilities that provide Covered Services to Members and shall require that Providers and facilities promptly provide those forms to a Member upon request.

2. CalOptima Health shall provide the Grievance and Appeal forms and procedures to a Member upon request, shall maintain copies on its website, and make Grievance and Appeals forms and procedures available at each CalOptima Health facility.

3. CalOptima Health's Customer Service Department shall assist a Member with questions regarding the procedures for filing an Appeal and shall triage Member calls and route Appeals to GARS via an electronic system.

B. Request for a Pre-Service Appeal (Standard and Expedited)

1. A CalOptima Health Member, or a Provider or Authorized Representative acting on behalf of a Member, and with the Member's written consent, may request a standard or Expedited Appeal within one hundred eighty (180) days from the date of the NABD/NOA from CalOptima Health or a Health Network orally or in writing by the following methods:

   a. Make a request to CalOptima Health's Customer Service Department, by telephone, or in person; or

   b. Make a request to CalOptima Health GARS, by facsimile, in writing, or through the CalOptima Health Website at www.caloptima.org.

C. Pre-Service Appeal Processing (Standard and Expedited)

1. Standard and Expedited Pre-Service Appeal Processing

   a. Upon receipt of a request for Appeal, GARS shall:

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i. Date stamp and document the substance of the Appeal, and any action taken, in the GARS database, verifying demographics, and network affiliation.

ii. Determine the category of Appeal (coverage dispute, medical necessity, non-coverage Appeal, or other) based on the Appeal, assign type and subtype descriptors, the responsible staff, and documentation of issue(s).

b. GARS staff shall review and immediately process Expedited Appeals and issue the decision within three (3) days of receipt. CalOptima Health shall provide oral notice of the Resolution of an Expedited Appeal and provide the Member and DMHC with a written statement on the disposition or Pending status of the Urgent Grievance within three (3) days of receiving the Grievance.

c. Expedited Appeals do not require Acknowledgement Letters as the Resolution letter is mailed within three (3) days of receipt date and time. The Resolution letter shall contain the same information required for standard Grievances in accordance with CalOptima Health Policy CC.1201: Member Grievance.

d. If CalOptima Health extends the timeframe for an Expedited Appeal determination by denying the request for an Expedited Appeal, then GARS staff shall notify the Member as follows:

i. Verbal Notification: Notify the appealing party and all involved parties of the decision to extend the timeframe for an Appeal determination, verbally, no later than one (1) business day of such decision; and

ii. Written Notification: Notify the Member of the decision, in writing, no later than two (2) days of the verbal notice and include:

a. The reason for the extension; and,

b. The Member's right to file a Grievance, in accordance with CalOptima Health Policy CC.1201: Member Grievance, if they disagree with CalOptima Health's decision to extend the timeframe.

2. Standard Pre-Service Appeal Processing

a. GARS staff shall process the Appeal regardless of whether a signed written Appeal request is received subsequently from the Member.

b. GARS staff shall send a Member, or a Provider or Authorized Representative, acting on behalf of the Member and with the Member's written consent, an Acknowledgment Letter within five (5) days after receipt of an Appeal, that includes the following information:

i. An acknowledgement that the Appeal was received;

ii. The name, telephone number, and address of the GARS staff member who may be contacted regarding the Appeal;

iii. An estimated completion date of Resolution; and

iv. Notice that the appealing party may submit additional information (written or in person) and/or request to review or obtain a copy of the records in connection with the Appeal.

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c. GARS staff shall send a written confirmation of the oral Appeal for Member's signature, in instances of an oral Appeal request made by the Member.

   i. The date of the oral Appeal establishes the filing date for the Appeal.

d. Triage and investigate the Appeal, and, as necessary, consult with the CalOptima Health department or Health Network responsible for the services or operations that are the subject of the Appeal.

e. Ensure an appeals nurse specialist in CalOptima Health's GARS investigates the Appeal, including any aspects of clinical care involved, by:

   i. Reviewing the initial decision and all documents related to the determination of Medical Necessity of the service requested, including any additional comments, documents, records, or other information supplied by a Provider or Member without regard to whether such information was submitted or considered in the initial action;

   ii. Obtaining and reviewing the Health Network's initial decision and supporting documentation, including relevant Medical Records; and

   iii. Preparing the case file for review by CalOptima Health's CMO or their Designee.

f. CalOptima Health shall utilize specialist consultants, as appropriate.

g. Escalate the Appeal for review of the factual findings, proposed Resolution, and any other relevant information, in accordance with CalOptima Health Policy HH.1109: Complaint Decision Matrix and shall issue a decision with respect to the Appeal.

h. Send the Member a NAR letter within thirty (30) days after receipt of the Appeal.

   i. The NAR letter shall describe the Appeal, and provide a clear and concise explanation of the reasons for the decision, including, but not limited to:

      a) The results of the Resolution and the date it was completed;

      b) If CalOptima Health upholds a denial determination that is based in whole or in part on Medical Necessity, it shall include the reasons for the decision and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination; notice that the determination may be considered by the DMHC's IMR system

      c) If CalOptima Health upholds a denial based on a determination that the requested service is not a covered benefit, it shall include the provision in the CalOptima Health plan contract, evidence of coverage, or Member handbook that excludes the service and identify the document and page or section containing the provision, or provide a copy of the provision and explain in clear and concise language how the exclusion applied to the specified service or benefit requested;

      d) If CalOptima Health overturns the denial determination, a clear and concise explanation of why the decision was overturned;

      e) Any referrals to the QI Department for quality of care review;

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f) Alternative resources or references, when applicable; and

g) The IMR process and an application with instructions, including the DMHC's toll-free telephone number for further information, and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

i. Translate NAR letters into Threshold Languages and offer oral interpretation for a NAR letter for all other languages, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

j. Close the case in the GARS database by documenting the disposition of the Appeal, reviewing entity(ies), decision and any action taken (if any), include a copy of the NAR letter in the electronic file and document any oral notification provided to the Member.

3. Expedited Pre-Service Appeal Processing

a. If CalOptima Health determines, for a request from a Member, or when the Provider indicates that taking the time for a standard Resolution could seriously jeopardize the Member's life or health or ability to maintain, or regarding maximum function, a Member, or a Provider or Member's Authorized Representative acting on behalf of the Member and with the Member's written consent, may request an Expedited Appeal to CalOptima Health as follows:

i. A CalOptima Health Member, or a Provider or Member's Authorized Representative acting on behalf of the CalOptima Health Member and with the Member's written consent, may request an Expedited Appeal by contacting CalOptima Health's Customer Service Department by telephone or in-person, or contacting CalOptima Health's Grievance and Appeals Resolution Services by facsimile, in writing, or through the CalOptima Health Website at www.caloptima.org.

ii. CalOptima Health staff shall inform the Member of limited time to present evidence in person or writing to support the Appeal and immediately notify the Member:

a) Of their right to contact DMHC regarding their Expedited Appeal; and

b) That there is no requirement for the Member to participate in the CalOptima Health Grievance process prior to applying to DMHC for review of the Expedited Appeal.

b. Upon receipt of a Member request for an Expedited Appeal, CalOptima Health's CMO or Designee shall review the request to determine if the expedited review criteria is met and shall conduct a medical review, as deemed necessary, based on whether:

i. A delay could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function based on a prudent layperson's judgment; or

ii. In the opinion of a Provider with knowledge of the Member's medical condition, a delay would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

c. CalOptima Health shall grant Expedited Appeal requests concerning admission, continued stay, or other health care services for a Member who has received Emergency Services but has not been discharged from a facility.

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d. Expedited Appeals filed by a physician shall be processed as expedited without further review.

e. CalOptima Health shall utilize specialist consultants, as appropriate.

f. CalOptima Health shall resolve an Expedited Appeal as quickly as the medical decision requires but no later than three (3) days after CalOptima Health receives the Expedited Appeal request.

g. CalOptima Health shall notify a Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, within twenty-four (24) hours, by telephone, and written notice within three (3) days of the oral notice if the Appeal does not meet Expedited Appeal criteria.

i. If the Grievance does not meet the criteria for urgent review, CalOptima Health shall notify the Member and DMHC that the Member's case will be processed as a standard Appeal and the Member's right to notify DMHC of the expedited review request.

h. CalOptima Health shall notify the Member, or a Provider or Authorized Representative acting on behalf of the CalOptima Health Member with the Member's written consent, of the Expedited Appeal decision through oral notice or in writing within three (3) days after receiving the Expedited Appeal request. CalOptima Health shall provide a written notice within one (1) business day after oral notice.

4. Pre-service Appeals Resolution (Standard and Expedited)

a. Except as otherwise provided in Section III.C.3. of this policy, CalOptima Health shall send to the Member and Providers, as appropriate, a NAR within thirty (30) days after receipt of the Appeal.

b. If CalOptima Health completely overturns the denial, the letter shall state the decision and the date of the decision. CalOptima Health shall also ensure the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.

c. If CalOptima Health does not completely overturn the denial, the NAR shall include information including: the title, qualification and specialty of the person making the decision, how the Member or Provider may obtain copies of the Appeal file documentation or criteria used to make the Appeal decision, the Member's right to request a standard or expedited IMR, and the Member's right to have a representative act on their behalf for an Appeal.

d. If CalOptima Health upholds a decision involving the delay, denial, or modification of health care services, the NAR shall include information regarding the title, qualification, and specialty of the person making the decision and the specific reasons for the Appeal decision, in easy-to-understand language, and a reference to the specific criteria, guideline or protocol used, and clinical reasons for the decision as it applies to the Member.

e. If CalOptima Health upholds an Appeal decision for health care services based in whole or in part on findings that the services are not Covered Services, the NAR shall include information regarding the title of the person making the decision and clearly specify the provisions of the contract that exclude that service, evidence of coverage or the Member handbook reference for excluded services and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested.

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f. CalOptima Health and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

D. Post-service Appeal Processing

1. CalOptima Health GARS staff shall obtain all documentation related to the Appeal, including but not limited to any claims submitted on behalf of the Member, Provider information, Member's referral and authorization history, and clinical history documentation on file, as well as any information provided by the Member, Authorized Representative, or Provider.

2. A GARS Appeals nurse shall investigate, review, and summarize the Appeal history and documentation, including any aspects of clinical care involved, for submission to CMO or their Designee for review.

3. All medical Appeals are referred to the CMO or their Designee who has the authority to require corrective action, is of the same or similar specialty, is able to treat complications that may result from the service or procedure and did not make the initial utilization management decision.

4. CalOptima Health shall utilize specialist consultants as appropriate.

5. Post-service Appeals Resolution

a. CalOptima Health shall send to the Member and Provider, as appropriate, a NAR within thirty (30) days after receipt of the Appeal.

b. If CalOptima Health completely overturns the decision, the NAR shall state the decision and the date of the decision. CalOptima Health shall also ensure the written response sent to the appealing party contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.

c. If CalOptima Health does not completely overturn the decision, the NAR shall include information regarding the name and title of the person making the decision, how the Member or Provider may obtain, upon request, copies of the Appeal file documentation or criteria used to make the Appeal decision; the right to continue to receive benefits Pending an IMR, and the Member's right to request a standard or expedited IMR, in accordance with CalOptima Health Policy HH.1108: State Hearing Process and Procedures and the Member's right to have a representative act on their behalf when they appeal.

d. If CalOptima Health upholds an Appeal decision, in whole or in part, the NAR shall describe the specific reasons for the Appeal decision in easy-to-understand language, a reference to the specific criteria, guideline or protocol used and clinical reasons for the decision as it applies to the Member.

e. CalOptima Health and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

D. If CalOptima Health is notified by DMHC that a Member has requested an IMR, CalOptima Health shall provide the following information within three (3) business days for standard appeals, or within twenty-four (24) hours for Expedited Appeals, unless otherwise advised in the notification:

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1. A copy of the Member's Medical Records in possession of CalOptima Health and its Health Networks related to the Member's medical condition, health care services being provided by CalOptima Health's Providers for the condition, and the Disputed Health Care Services requested by the Member.

2. Any newly developed or discovered relevant Medical Records in possession of CalOptima Health shall be immediately forwarded to the IMR organization and the Member or the Member's Provider, if authorized by the Member, unless the offer of Medical Records is declined or otherwise prohibited by law.

3. Copies of all information CalOptima Health provided to the Member and Providers and Member provided to CalOptima Health concerning the plan and Provider decisions regarding the Member's condition, care, or support of the Disputed Health Care Service, including copies of CalOptima Health's Resolution letter.

4. Copies of any other relevant documents or information used by CalOptima Health or its Providers in determining whether the Disputed Health Care Service should be provided, and any statements explaining the reasons for the decision to deny, modify, or delay Disputed Health Care Services on the basis of medical necessity.

5. The confidentiality of all Medical Record information and medical information provided outside of the Medical Record shall be maintained pursuant to applicable state and federal laws.

E. Upon notification that DMHC, through the IMR process, has ruled a Disputed Health Care Service as Medically Necessary, CalOptima Health will immediately contact the Member and arrange to authorize the services as expeditiously as the Member's health condition requires.

1. In the case of reimbursement for services already rendered, CalOptima Health shall reimburse the Provider or Member, whichever applies, within five (5) business days.

2. In the case of services not yet rendered, CalOptima Health shall authorize the services within five (5) business days of receipt of the written decision from the DMHC, or sooner if appropriate for the nature of the Member's medical condition and shall inform the Member and Provider of the authorization.

3. In the case of an external exception request for pharmacy related Appeals that is deemed by the DMHC to be Medically Necessary, CalOptima Health will facilitate authorization as expeditiously as the Member's health condition requires, not to exceed seventy-two (72) hours.

F. Notices, Records, and Reports

1. Upon enrollment, and annually thereafter, CalOptima Health shall inform a Member, in writing, of the locations for filing a Grievance, telephone numbers where a Grievance may be submitted, related procedures regarding the Grievance Process, information regarding DMHC review process, the IMR system, and the DMHC's toll-free telephone number and website address. CalOptima Health shall provide these notices in Threshold Languages, as required by DMHC and Covered California.

2. CalOptima Health shall keep in its files written records of each Appeal, including copies of Appeal records of any sub-contracting entity delegated the responsibility to maintain and resolve Appeals. The records shall include all Medical Records, documents, evidence of coverage and other relevant information upon which the plan relied in reaching its decision, the date and time of receipt, Member's name, description of the complaint or problem, names of the CalOptima Health staff who received the Appeal and who is designated as the contact person,

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description of the action taken to investigate/resolve the problem, Resolution proposed by GARS or the medical professional responsible for making utilization management decision, the name of the CalOptima Health Provider or staff responsible for resolving the Appeal, the date of notification to the Member of Resolution, and all Appeal Resolution letters. CalOptima Health shall maintain the written records, for a minimum of ten (10) years.

3. CalOptima Health shall continually evaluate and analyze Appeal data to identify systemic patterns of improper services denials and other trends impacting health care delivery to Members.

4. CalOptima Health shall submit, on a quarterly basis, aggregated and detailed Appeals data to the Quality Assurance Committee.

5. CalOptima Health shall establish and maintain a system of aging of Appeals that are Pending and unresolved for thirty (30) days or more.

6. Aging Grievances Report. CalOptima Health's Grievance system shall track and document aging Grievances, which are Grievances that are Pending and unresolved for thirty (30) days or more. CalOptima Health shall provide a quarterly report to DMHC of Grievances Pending and unresolved for thirty (30) or more days. The report shall be verified by CalOptima Health's Director of Grievance and Appeals Resolution Services and submitted as specified in Title 28, California Code of Regulations § 1300.68(i).

7. The written record of Appeals shall be reviewed periodically by CalOptima Health's Governing Board, the Member Advisory Committee, and Provider Advisory Committee and the Chief Operating Officer or Designee, all who have the authority to require corrective action. The review and recommendations of such shall be thoroughly documented.

    a. GARS shall present to the QIHEC on a quarterly basis any trends identified including those related to health inequities, implicit bias, and discrimination. GARS will update the QIHEC on any actions taken by the GARS Committee.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Health and Safety Code §§ 1365, 1367.01(e),(h)(3), and (j),1368 (a)(1), (a)(4)(B), 1368.01(a)-(b), 1368.016, 1368.02(b), 1367.24, 1368.015, 1370.2, 1371.34, 1374.30 (e), (i), (j)(1) and (3) (l), (m), (n), 1374.31, 1374.34(a).
B. CalOptima Health Contract with Covered California
C. CalOptima Health Policy CC.1201: Member Grievance
D. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
E. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
F. CalOptima Health Policy GG.1611: Potential Quality Issue Review Process
G. CalOptima Health Policy HH.1104: Complaints of Discrimination
H. CalOptima Health Policy HH.1108: State Hearings Process and Procedures
I. CalOptima Health Policy HH.1109: Complaint Decision Matrix
J. Department of Managed Health Care All Plan Letter (APL) 22-021: Quarterly Grievance Reports (Revised November 8, 2022)
K. Standards and Guidelines for the Accreditation of Health Plans
L. Title 28, California Code of Regulations (C.C.R.), §§ 1300.68(a), (a), (b)(3)-(b)(8), 1300.85,

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1300.85.01.

M. Title 45, Code of Federal Regulations (C.F.R.), § 156.122(c).

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1200	Member Appeal Process	Covered California

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IX. GLOSSARY

Term	Definitions
Acknowledgement Letter	A written statement acknowledging receipt of an Appeal.
Adverse Benefit Determination	Any of the following actions taken by CalOptima Health: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a complete claim as specified in 28 CCR 1300.71(a). 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard Resolution of Grievances and Appeals. 6. The denial of a Member's request to dispute financial liability.
Appeal	A review by CalOptima Health of an Adverse Benefit Determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes required in this policy.
Appeal Process	The process by which CalOptima Health and its Health Networks address and provide Resolution to all Appeals.
Authorized Representative	An individual who is (1) the legal representative or otherwise legally able to act on behalf of a Member, as the law of the State in which the Member resides may allow; (*e.g.*, court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity), or (2) appointed in writing by a competent Member to act on behalf of the member for a limited purpose (*e.g.*, to represent the member in DHCS State Fair Hearings, DMHC Independent Medical Reviews, filing Grievances and Appeals, claims adjudications). The DMHC Authorized Assistant Form may be used to appoint an authorized assistant to assist the Member with Independent Medical Review or complaint, provided a power of attorney for health care decisions or other legal document is submitted by an individual seeking to represent a Member who does not have legal capacity to appoint an authorized assistant.
Covered Service	Health care services that are covered benefits under CalOptima Health's contract with Covered California as further described in the evidence of coverage and supporting documents.
Department of Managed Health Care (DMHC)	California state agency that regulates and oversees health maintenance organizations and other managed care plans.

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Term	Definitions
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.
Disputed Health Care Service	Any health care service eligible for coverage and payment under a CalOptima Health plan contract that has been denied, modified, or delayed by a decision of CalOptima Health, or by one of its contracting Providers, in whole or in part due to a finding that the service is not Medically Necessary. A decision regarding a Disputed Health Care Service relates to the practice of medicine and is not a coverage decision.
Emergency Services	In cases involving a claim for out of plan emergency services that a Provider determined were Medically Necessary to screen and stabilize the Member's condition, emergency services are services for emergency medical conditions as defined in Title 28 of the California Code of Regulations § 1300.71.4 where the Member has obtained the services without prior authorization from CalOptima Health or from a contracting Provider.
Expedited Appeal	A type of Urgent Grievance involving an Adverse Benefit Determination.
Governing Board	CalOptima Health's Board of Directors or a similar body, and/or its executive management, that has the authority to manage and direct CalOptima Health's affairs and activities, including, but not limited to, approving initiatives and establishing CalOptima Health's policies and procedures.
Grievance	A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.
Health Network	A physician hospital consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a health maintenance organization (HMO), subcontractor, or first tier entity, that contracts with CalOptima Health to provide Covered Services to members.
Independent Medical Review (IMR)	A review of CalOptima Health'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 CalOptima Health pursuant to Health and Safety Code § 1374.30 and Title 28 California Code of Regulations §1300.74.30.
Medical Record	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.

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Term	Definitions
Medically Necessary or Medical Necessity	Health care and related services and supplies provided to a Member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care Provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results. For Medically Necessary Treatment of a mental health or substance use disorder, Medical Necessity shall include a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) in accordance with the generally accepted standards of mental health and substance use disorder care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; and (iii) not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care Provider, as required by Health and Safety Code §1374.72 (a)(3)(A).
Member	An individual enrolled in a CalOptima Health program.
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.
Pending	Grievances or Appeals that are not resolved within thirty (30) days, or that are referred to the DMHC's complaint or independent medical review system or other external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process, as applicable.
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima Health to advise its Board of Directors on issues impacting the CalOptima Health Provider community.
Relative	A parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the Member.
Resolved/Resolution	The Grievance has reached a final conclusion with respect to the Member's submitted Grievance and there are no Pending Member appeals within CalOptima Health's Grievance system, including any entities with delegated authority.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.
Threshold Languages	The non-English threshold and concentration standard languages in which CalOptima Health is required to provide written translations of Member Information, as determined by DHCS.
Urgent Grievance	Grievances that involve an imminent and serious threat to the mental or physical health of the Member, including but not limited to severe pain, potential loss of life, limb or major bodily function, or lack of timeliness that could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.

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Policy:	CC.1201
Title:	**Member Grievance**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2027
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☒ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy defines the process by which CalOptima Health addresses and resolves Grievances from a Member, or a Provider or Authorized Representative acting on behalf of a Member with the Member's written consent, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima Health shall establish and maintain a Grievance Process pursuant to which a Member, or a Provider or Authorized Representative acting on behalf of a Member with the Member's written consent, may submit a Grievance for review and Resolution either orally or in writing.

B. CalOptima Health's Grievance Process shall address the receipt, handling, and disposition of a Member's Grievance, in accordance with applicable statutory, regulatory, and contractual requirements.

C. A Member need not use the term "Grievance" for a Complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. If a Member declines to file a Grievance, the Complaint shall still be categorized as a Grievance.

D. Members have the right to submit a Grievance against named individual(s), subcontractors, downstream subcontractors, or staff for failure to provide Trans-Inclusive Health Care. If a Grievance Resolution on Trans-Inclusive Health Care is decided in the Member's favor, the Grievance and Appeals Resolution Services (GARS) specialist will notify the Human Resources (HR) or Provider Relations (PR) departments for those individuals that must retake the Trans-Inclusive Health Care cultural competency training.

1. Upon notification from GARS, HR (for employee-related Grievances) and/or PR (for Provider, vendor, and subcontractor related Grievances) will conduct and track re-training as follows:

   a. The Transgender, Gender Diverse, Intersex (TGI) cultural competency re-training will be conducted within forty-five (45) calendar days of the notification and before the individual requiring re-training has direct contact with Members again.

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E. CalOptima Health shall assist a Member requiring assistance with filing a Grievance, including, but not limited to, a Member with limited English proficiency, disabilities, or cultural needs.

F. CalOptima Health shall ensure prompt review and investigation of a Grievance. A Health Network may participate in the review and investigation of a Grievance.

G. CalOptima Health shall process expedited requests timely in instances where a Provider indicates, or CalOptima Health determines, that the standard timeframe may seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

H. CalOptima Health shall ensure that the person making the final decision on the Grievance did not participate in any decisions related to the Grievance and they are not the subordinate of any person involved in the initial determination. If the Grievance is regarding the denial of an expedited resolution of an Appeal or involves clinical issues, the person making the final decision shall also have the clinical expertise in treating a Member's condition or disease.

I. CalOptima Health shall refer all potential medical quality-of-care issues identified through the Grievance Process to the Quality Improvement (QI) Department for review.

J. CalOptima Health shall ensure that there is no discrimination against a Member, a Member's Authorized Representative, or Provider on the grounds that the individual filed a Grievance, as required by federal and state nondiscrimination law and in accordance with CalOptima Health Policy HH.1104: Complaints of Discrimination.

K. CalOptima Health shall inform a Member of their right to file a Grievance through CalOptima Health for at least one hundred eighty (180) calendar days following any incident to express dissatisfaction about any matter other than an action resulting in a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA), in accordance with the provisions of this Policy.

1. A Member's Provider or Authorized Representative, acting on behalf of the Member with the Member's written consent, has the right to file a Grievance within the one hundred eighty (180) day timeframe specified above.

L. CalOptima Health shall inform a Member, during the Grievance Process, of their right to request an Independent Medical Review (IMR) or file a Complaint with the Department of Managed Health Care (DMHC) after the Grievance process in accordance with CalOptima Health Policy CC.1200: Member Appeal Process.

1. If a Member has filed a Grievance with CalOptima Health and the disputed decision is upheld or the Grievance remains unresolved after thirty (30) calendar days, the Member shall not be required to participate in CalOptima Health's Grievance Process for more than thirty (30) calendar days. In the case of a Grievance that requires expedited review, the Member shall not be required to participate in CalOptima Health's Grievance Process.

M. CalOptima Health shall give a Member a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Grievance, evidence, testimony, facts, and law in support of the Grievance. CalOptima Health or a Health Network shall inform the Member of the limited time available to present evidence sufficiently in advance of the Resolution timeframes, including for Urgent Grievances.

N. CalOptima Health shall consider all comments, documents, records, and other information submitted by the Member, or the Member's Authorized Representative or Provider, regardless of whether such information was submitted or considered during the initial review.

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O. CalOptima Health shall provide the opportunity, before and during the Grievance Process, to examine and or obtain a copy of the Member's case file, including the Medical Record, and any other relevant documents and records considered during the Grievance Process, upon request by the Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent. CalOptima Health shall provide records at no cost.

P. CalOptima Health and its Health Networks shall provide culturally and linguistically appropriate notices of the Grievance Process to Members, including language assistance taglines and a notice of non-discrimination in compliance with the requirements set forth by the DMHC, and in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

Q. A Member, or a Provider or Authorized Representative acting on behalf of the Member with the Member's written consent, may submit a request to Appeal a decision not related to a utilization management decision with any supporting documentation to GARS. Such request shall be considered a Non-Coverage Appeal, and CalOptima Health shall process the request as a Grievance and in accordance with Section III.E. of this policy.

R. CalOptima Health shall be available twenty-four (24) hours a day, seven (7) days a week to receive communications from the DMHC regarding Urgent Grievances. During normal work hours, CalOptima Health shall respond to the DMHC within thirty (30) minutes after initial contact and within one (1) hour during non-work hours.

1. CalOptima Health has designated plan representatives, including back-up plan representatives as necessary, who have the authority to resolve Urgent Grievances and authorize the provision of health care services in a medically appropriate and timely manner.

S. Responsible staff

1. CalOptima Health's Chief Operating Officer shall have primary responsibility for:

a. Maintenance of the Grievance Process;

b. Review of the operations; and

c. Identification of any emerging or systemic issues of Grievances and Appeals and/or patterns of improper service denials in the formulation of policy changes and procedural improvements to CalOptima Health's administration of the program.

2. CalOptima Health's Director of GARS shall have primary responsibility for the oversight of the Grievance Process.

III. PROCEDURE

A. Unless otherwise specified, CalOptima Health shall resolve all possible levels of internal Grievances or Appeals within thirty (30) calendar days of the receipt of the Grievance.

B. Assistance to Members

1. CalOptima Health shall make Complaint forms and procedures for filing a Grievance available at each facility that provides Covered Services to Members, on CalOptima Health's website, and from each contracting Provider's office or facility.

2. CalOptima Health shall promptly provide Complaint forms and procedures to a Member upon request.

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3. CalOptima Health's Customer Service Department shall assist a Member with questions regarding the procedures for filing Grievances and shall triage Member calls and route Grievances to the GARS Department via its electronic system.

4. CalOptima Health shall ensure that Members accessing the Grievance system are given assistance in completing Grievance forms and other procedural steps, including but not limited to providing auxiliary aids and services upon request, such as interpreter services and a toll-free number with TTY/TDD and interpreter capability.

C. Exempt Grievances

1. Grievances received over the telephone that are not coverage disputes, Disputed Health Care Services involving medical necessity, or experimental or investigational treatment, and that are resolved by the close of the next business day are exempt from the requirement from sending a written acknowledgment and response and shall be classified as an Exempt Grievance.

2. CalOptima Health Customer Service and GARS Departments shall maintain records and logs of Standard, Urgent, and Exempt Grievances, including the date of receipt, name of complainant, Member's name and Member identification number, nature of the Grievance, name(s) of the CalOptima Health staff who received the Grievance, and name of the CalOptima Health staff who Resolved the Grievance.

3. CalOptima Health Customer Service Department shall, on a monthly basis, provide an Exempt Grievance and "Declined Grievance" report to GARS to be aggregated for tracking and trending purposes as with other Grievances.

4. A Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, may express dissatisfaction, or discontent, to the CalOptima Health Customer Service Department by telephone, or in person.

5. The CalOptima Health Customer Service Department staff shall:

   a. Identify and document the nature of the dissatisfaction expressed by the Member, Member's Authorized Representative, or Provider acting on behalf of a Member;

   b. Document all actions taken to address the dissatisfaction expressed by the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member, as well as the Resolution provided in response to the dissatisfaction expressed by the Member, Member's Authorized Representative, or Provider acting on behalf of the Member; and

   c. If the Grievance is resolved by the close of the next business day, it shall be classified as an Exempt Grievance.

6. If CalOptima Health Customer Service Department staff is unable to provide Resolution to the Member, a Member's Authorized Representative, or Provider acting on behalf of a Member regarding the dissatisfaction, or discontent by close of the next business day, the CalOptima Health Customer Service staff shall:

   a. Educate the Member, Member's Authorized Representative, or Provider acting on behalf of a Member of Grievance rights in accordance with this Policy and inform them that the issue(s) will be referred to the CalOptima Health GARS Department;

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b. Inform the Member, Member's Authorized Representative, or Provider acting on behalf of a Member of the Resolution timeframes; and

c. If the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member agrees to the Grievance referral, route the Grievance to the GARS Department.

7. If the Member, Member's Authorized Representative, or Provider acting on behalf of a Member expressly declines to file the Grievance, Customer Service Department staff shall:

a. Categorize the issue as a Grievance;

b. Forward potential quality of care declined Grievances to the CalOptima Health QI Department for review;

c. Continue to assist the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member until the Grievance is fully resolved; and

d. Close the Grievance with the "Declined Grievance" disposition code.

D. Grievance Process

1. A Member, or Provider or Authorized Representative acting on behalf of the Member, may file a Grievance:

a. With CalOptima Health's Customer Service Department, by telephone, or in person; or

b. With CalOptima Health GARS, by facsimile, in writing, or through the CalOptima Health website at www.CalOptima.org.

2. CalOptima Health shall provide language assistance for Threshold Languages and language line interpretation services, as needed, to register and resolve Grievances in all other languages.

3. In the event an oral Grievance is received, CalOptima Health will process the Grievance regardless of whether a signed, written Grievance is subsequently received from the Member.

4. CalOptima Health shall process a Grievance for discrimination as required by applicable federal and state nondiscrimination laws and in accordance with CalOptima Health Policy HH.1104: Complaints of Discrimination.

5. GARS shall:

a. Date stamp and document the substance of the Grievance, and any action taken, including but not limited to the Member's previous Complaint history and follow-up activities associated with the Complaint, in the GARS database, verifying demographics and network affiliation.

b. Determine the category of Grievance, including but not limited to the following categories: quality of care, quality of service, access to care, and other, based on the Grievance. Assign type and subtype descriptors, the responsible staff, and documentation of issue(s).

c. Send the Member an Acknowledgment Letter within five (5) calendar days after receipt of a Grievance, indicating receipt of the Grievance, the date of receipt of the Grievance, and providing the name, telephone number and address of the GARS staff member whom the Member may contact regarding the Grievance, and provide the Member with an estimated

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completion date of Resolution. The Acknowledgment Letter shall also include information regarding a Member's right to participate in the Grievance process, as described in this policy.

d. Triage and investigate the Grievance, and, as necessary, consult with the CalOptima Health department or Health Network responsible for the services or operations that are the subject of the Grievance.

e. CalOptima Health shall take into consideration the Member's medical condition when determining the response time, particularly for Urgent Grievances, as described in this policy.

f. Refer all Grievances related to potential medical quality of care issues to the QI Department for immediate review by CalOptima Health's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.

g. Review and immediately process all Grievances that may seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function, on an expedited basis and issue the decision within seventy-two (72) hours of receipt. CalOptima Health shall provide oral notice of the Resolution of an Urgent Grievance to the DMHC. The procedures for an Urgent Grievance shall include:

   i. Immediate notification to the Member or their Authorized Representative of the shortened timeframe to submit information related to their case, and of their right to notify the DMHC of their Grievance.

   ii. A written statement to the DMHC and the Member on the disposition or Pending status of the Urgent Grievance within three (3) calendar days of receipt of the Grievance by CalOptima Health.

h. Send the Member, or Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, a Grievance Resolution Letter, not to exceed thirty (30) calendar days from the date CalOptima Health receives the oral or written Grievance.

i. Ensure that Members, or a Member's Provider or Authorized Representative, have equal access to, and can fully participate in, the Grievance process by providing assistance to Members, or a Member's Provider or Authorized Representative, with disabilities, limited English proficiency, vision disorders, or other communicative impairments by providing the following services in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services:

   i. Translate Grievance correspondence into Threshold Languages and offer oral interpretation for Grievance correspondence for all other languages.

2. The Grievance Resolution Letter shall describe the Grievance and provide a clear and concise explanation of the reasons for the decision, including but not limited to:

   a. Summary of the Member's Grievance;

   b. The investigation made in the review process, including any referrals to the QI Department for medical quality of care review;

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c. When possible, the outcome of the review; and

d. Alternative resources or references, when applicable.

3. GARS staff shall close the case in the GARS database by documenting the disposition of the Grievance, including whether the Grievance was resolved in favor of the Member or CalOptima Health, reviewing entity(ies), decision and any additional action taken (if any), include a copy of the Grievance Resolution Letter and document any oral notification provided to the Member and save the electronic file.

4. For Grievances involving contested claims, GARS shall refer the claim for review to a licensed and competent health care professional to evaluate the clinical issues of the appealed claim, as applicable.

5. Grievances for Pharmacy Services: A Member or the Member's Designee or guardian may Appeal a denial of an exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request by filing a Grievance in accordance with this policy pursuant to Health and Safety Code § 1367.206 and in compliance with (c) of § 156.122 of Title 45 of the Code of Federal Regulations.

6. Grievances Related to Privacy Rights: CalOptima Health shall inform a Member of their right to file a Grievance with CalOptima Health or with the Secretary of Health and Human Services regarding violations of their privacy rights, in accordance with CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII.

7. For Grievances involving the cancellation, rescission, or nonrenewal of a CalOptima Health plan contract, CalOptima Health shall continue to provide coverage to the Member under the terms of the CalOptima Health plan contract until a final determination of the Member's request for review has been made by CalOptima Health, or the DMHC pursuant to Health and Safety Code § 1365. This paragraph shall not apply if CalOptima Health cancels or fails to renew the Member's health plan contract for nonpayment of premiums.

E. Non-Coverage Appeals

1. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may submit a request to Appeal a decision not related to a utilization management decision with any supporting documentation to GARS within sixty (60) calendar days of the date of the Non-Coverage Decision Resolution Letter. This type of Grievance is considered a Non-Coverage Appeal and is separate from the Appeal process in CalOptima Health Policy CC.1200: Member Appeal Process.

2. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may file the Non-Coverage Appeal with CalOptima Health's Customer Service Department by telephone or in person, or with GARS via facsimile, in writing or through the CalOptima Health Website at www.CalOptima.org.

3. CalOptima Health shall provide language assistance by CalOptima Health staff for Threshold Languages and language line interpretation services, as needed, to register and resolve Grievances in all other languages.

4. The CMO or their Designee not involved in the initial review shall conduct the review of the decision.

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5. Upon receipt of the Non-Coverage Appeal, GARS shall:

   a. Date stamp and document the substance of the Non-Coverage Appeal, and any action taken, into its electronic system, verifying demographics and network affiliation;

   b. Determine the category of the Non-Coverage Appeal based on the Grievance, assign type and subtype descriptors, the responsible staff, and documentation of issue(s);

   c. Send the Member an Acknowledgment Letter within five (5) calendar days after receipt of a Non-Coverage Appeal, indicating receipt of the Grievance and identifying a GARS staff member whom the Member may contact regarding the Non-Coverage Appeal;

   d. Triage and investigate the Non-Coverage Appeal and, as necessary, consult with the CalOptima Health department or Health Network responsible for the services or operations that are the subject of the Complaint;

   e. Refer all Non-Coverage Appeals related to potential quality of care issues to the QI Department for review by the CalOptima Health CMO or their Designee and any action deemed necessary under the quality review process;

   f. Review and immediately process all Non-Coverage Appeals involving an imminent and serious threat to the health of a Member including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis for effectuation of the decision within seventy-two (72) hours of receipt:

      i. CalOptima Health shall expedite its review of the Urgent Grievance when a Member, an Authorized Representative, or treating physician provides notice to CalOptima Health. Notice need not be in writing but may be accomplished by a documented telephone call.

   g. Notify the Member of the Non-Coverage Appeal decision in writing within thirty (30) calendar days of the receipt of the Grievance and include the next level Appeal rights attachments including the right to file a Complaint with DMHC.

      i. CalOptima Health shall provide language assistance, by CalOptima Health staff for Threshold Languages and language line interpretation services, as needed to register and resolve Grievances in all other languages.

      ii. For Grievances appealing Non-Coverage Appeal decisions, including but not limited to requests for access to out-of-network Providers or change of Health Networks, the Grievance Resolution Letter shall include:

         a) Summary of the Member's Non-Coverage Appeal;

         b) Description of actions taken to review the request;

         c) Date and name of position of staff involved in the review; and

         d) Date of the issuance of the decision.

6. CalOptima Health shall take immediate action to implement the decision, in accordance with the Grievance Resolution Letter.

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7. GARS staff shall close the case in its electronic system by documenting the disposition of the Non-Coverage Appeal, reviewing entity(ies), decision and any additional action taken (if any), and include a copy of the Grievance Resolution Letter and document any oral notification provided to the Member, and Resolution date.

F. Notices, Records, and Reports

1. Upon enrollment, and annually thereafter, CalOptima Health shall inform a Member, in writing, of the locations for filing a Grievance, telephone numbers where a Grievance may be submitted, related procedures regarding the Grievance Process, information regarding the DMHC review process, the Independent Medical Review system, and the DMHC's toll-free telephone number and website address. CalOptima Health shall provide these notices in Threshold Languages, as required by the DMHC and Covered California.

2. CalOptima Health shall keep in its files written records of each Grievance, including copies of Grievance records of any sub-contracting entity delegated the responsibility to maintain and resolve Grievances. The records shall include all Medical Records, documents, evidence of coverage and other relevant information upon which the plan relied in reaching its decision, the date and time of receipt, Member's name, description of the Complaint or problem, names of the CalOptima Health staff who received the Grievance and who is designated as the contact person, description of the action taken to investigate/resolve the problem, Resolution proposed by GARS or the medical professional responsible for making a utilization management decision, the name of the CalOptima Health Provider or staff responsible for resolving the Grievance, the date of notification to the Member of Resolution, and all Grievance Resolution Letters. CalOptima Health shall maintain the written records, for a minimum of ten (10) years.

3. CalOptima Health shall continually evaluate and analyze Grievance data to identify systemic patterns of improper services denials and other trends impacting health care delivery to Members.

4. On a quarterly basis, CalOptima Health shall submit all recorded Member Grievances related to access to care, quality of care, and denial of services to the QI Committee to review and take appropriate action to remedy any problems identified in such reviews.

5. Aging Grievances Report. CalOptima Health's Grievance system shall track and document aging Grievances, which are Grievances that are Pending and unresolved for thirty (30) calendar days or more and shall include a brief explanation of the reasons for each Pending and unresolved Grievance. CalOptima Health shall provide a quarterly report to the DMHC of Grievances Pending and unresolved for thirty (30) or more calendar days. The report shall be verified by CalOptima Health's Director of GARS and submitted as specified in Title 28, California Code of Regulations § 1300.68(i).

6. CalOptima Health shall submit on a quarterly basis aggregate and detailed Grievance data to the Quality Assurance Committee.

7. CalOptima Health Customer Service and GARS Departments' management staff shall, on a monthly basis, review reports for tracking and trending of Exempt Grievances by Provider, Health Network, and Grievance category.

8. GARS shall present to the Quality Improvement Health Equity Committee (QIHEC) on a quarterly basis any trends identified including those related to health inequities, implicit bias, and discrimination. GARS will update the QIHEC on any actions taken by the GARS Committee.

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9. The written record of Grievances, including Exempt Grievances, shall be reviewed periodically by CalOptima Health's Board of Directors, the Member Advisory Committee, and Provider Advisory Committee, and the Chief Operating Officer or Designee, all who have the authority to require corrective action. The review and recommendations of such shall be thoroughly documented.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Health and Safety Code §§ 1365, 1367.01(e),(h)(3), and (j),1368 (a)(1), (a)(4)(B), 1368.01(a)-(b), 1368.016, 1368.02(b), 1367.24, 1368.015, 1370.2, 1371.34, 1374.30 (e), (i), (j)(1) and (3) (l), (m), (n), 1374.31, 1374.34(a).
B. CalOptima Health Contract with Covered California
C. CalOptima Health Policy CC.1200: Member Appeal Process
D. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
E. CalOptima Health Policy GG.1611: Potential Quality Issue Review Process
F. CalOptima Health Policy HH.1104: Complaints of Discrimination
G. CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII
H. DMHC All Plan Letter (APL) 22-021: Quarterly Grievance Reports (Revised November 8, 2022)
I. Standards and Guidelines for the Accreditation of Health Plans
J. Title 28, California Code of Regulations, §§ 1300.68(a), (a), (b)(3)-(b)(8), 1300.68.01, 1300.85, 1300.85.1.
K. Title 45, Code of Federal Regulations, § 156.122(c).

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1201	Member Grievance	Covered California

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IX. GLOSSARY

Term	Definition
Acknowledgment Letter	A written statement acknowledging receipt of a Grievance.
Adverse Benefit Determination	Any of the following actions taken by CalOptima Health: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a complete claim as specified in 28 CCR 1300.71(a). 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard Resolution of Grievances and Appeals. 6. The denial of a Member's request to dispute financial liability.
Appeal	A review by CalOptima Health of an Adverse Benefit Determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes required in CalOptima Health Policy CC.1200: Member Appeals Process..
Authorized Representative	For purposes of this policy, an individual appointed by a Member, or a Member's parent, guardian, or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an Appeal or Grievance
Complaint	A complaint is the same as a Grievance, as defined below.
Covered Services	Health care services that are covered benefits under CalOptima Health's contract with Covered California as further described in the evidence of coverage and supporting documents.
Department of Managed Health Care (DMHC)	California state agency that regulates and oversees health maintenance organizations and other managed care plans.
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.
Disputed Health Care Service	Any health care service eligible for coverage and payment under a CalOptima Health plan contract that has been denied, modified, or delayed by a decision of CalOptima Health, or by one of its contracting Providers, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision.

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Term	Definition
Exempt Grievance	Grievances received by telephone, fax, email, or online through CalOptima Health's internet website that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt
Grievance	A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A Complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.
Grievance Process	The process by which CalOptima Health and its Health Networks address and provide resolution to all Grievances.
Grievance Resolution Letter	A written statement explaining the disposition of a Grievance based on a review of the facts, relevant information, and documentation.
Health Network	A physician hospital consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a health maintenance organization (HMO), subcontractor, or first tier Entity, that contracts with CalOptima Health to provide Covered Services to members.
Medical Record	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.
Member	An individual enrolled in a CalOptima Health program.
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-Coverage Appeal	Grievances about decisions that are not related to utilization management decisions.
Non-Coverage Decision Resolution Letter (Organization Determination)	Any determination made by CalOptima Health with respect to any of the following: 1. Payment for temporarily out-of-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider that the Member believes: a. Are covered under CalOptima Health's Covered California plan; or b. If not covered under CalOptima Health's Covered California plan, should have been furnished, arranged for, or reimbursed by CalOptima Health. 3. CalOptima Health's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by CalOptima Health; 4. Reduction or premature discontinuation of a previously authorized service; or 5. CalOptima Health's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.

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Term	Definition
Pending	Grievances or Appeals that are not resolved within thirty (30) calendar days, or that are referred to the DMHC's complaint or independent medical review system or other external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process.
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima Health to advise its Board of Directors on issues impacting the CalOptima Health Provider community.
Resolved/Resolution	The Grievance has reached a final conclusion with respect to the Member's submitted Grievance and there are no Pending Member appeals within CalOptima Health's Grievance system, including any entities with delegated authority.
Standard Grievance	A Grievance that does not meet the criteria to be treated as an Exempt or Urgent Grievance.
Threshold Languages	The non-English threshold and concentration standard languages in which CalOptima Health is required to provide written translations of Member Information, as determined by DHCS.
Trans-Inclusive Health Care	Comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex (TGI) and honors an individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding, and respect.
Urgent Grievance	Grievances that involve an imminent and serious threat to the mental or physical health of the Member, including but not limited to severe pain, potential loss of life, limb or major bodily function, or lack of timeliness that could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.

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Policy:	CC.1001
Title:	**Claims Processing for Covered Services for which CalOptima Health is Financially Responsible**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2027
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☒ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy describes the process by which CalOptima Health ensures timely processing of claims and payment for Covered Services for which CalOptima Health is financially responsible.

II. POLICY

A. CalOptima Health shall process claims in compliance with , California Code of Regulations (CCR) Title 28 Section 1300.71 and Health and Safety Code (HSC) Sections 1371 through 1371.39, and related state, federal, and regulatory requirements.

B. CalOptima Health shall establish and maintain administrative processes, or contract with a claims processing organization, to accept and adjudicate claims for health care services provided to Members, in accordance with the provisions of this Policy and the California Code of Regulations.

C. CalOptima Health shall ensure timely compliance with claims payment obligations and claims settlement practices.

D. CalOptima Health shall not impose a deadline for the receipt of a claim that is less than ninety (90) calendar days for a contracted Provider or one hundred eighty (180) calendar days for a Non-Contracted Provider, after the date of service, except as required by state or federal law or regulation.

E. CalOptima Health shall identify and acknowledge the receipt of each claim, whether or not it is a Complete Claim, and disclose the recorded date of receipt. CalOptima Health may provide an electronic method of notification, by which the Provider may readily confirm CalOptima Health's receipt of the claim and the recorded date of receipt as follows:

1. In the case of an electronic claim, within two (2) working days of the receipt of the claim; or

2. In the case of a paper claim, within fifteen (15) working days of receipt of the claim.

F. CalOptima Health may review a claim for National Correct Coding Initiative (NCCI) edits and may contest or deny a claim based on improper coding. CalOptima Health may subcontract with a third-party

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vendor to review claims for NCCI edits and improper billing practices.

G. Claims Processing Timelines

1. CalOptima Health shall process and adjudicate ninety-five (95%) percent of Complete Claims from Providers within thirty (30) calendar days of receipt.

2. CalOptima Health shall notify a Provider of a Contested or Denied Claim for Covered Services within thirty (30) calendar days after receipt of such claim. If CalOptima Health fails to notify the Provider of a Contested or Denied Claim, CalOptima Health shall consider the claim a Complete Claim, and shall pay, in accordance with the timelines for Complete Claims as set forth in this Policy.

H. CalOptima Health shall reimburse a Provider claim for Covered Services for which CalOptima Health is responsible, in accordance with CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible. Covered Services shall include payment for Emergency Services and Care which do not require authorization.

I. CalOptima Health shall have a process to recoup Overpayments made to Providers when claims payments exceed the allowed amount.

1. CalOptima Health may recoup Overpayments, and written notification must be sent to Providers within three hundred sixty-five (365) days of the date the original claim was paid. Providers must either contest or pay the requested monies within thirty (30) working days of receipt of the notification of Overpayment.

2. The three hundred sixty-five (365) day time limit shall not apply if the Overpayment was caused in whole, or in part, by Fraud, or misrepresentation, on the part of the Provider.

3. Failure to timely repay Overpayments will result in the addition of interest charges.

J. CalOptima Health shall not request reimbursement for the Overpayment of a claim, including requests made pursuant to Health and Safety Code, Section 1371.1, unless CalOptima Health sends a written request for reimbursement to the Provider within three hundred sixty-five (365) days from the date the Overpayment was made.

K. CalOptima Health shall pay interest and applicable penalties on all uncontested claims not paid within thirty (30) calendar days, in accordance with Section III.G. of this Policy. The interest is determined by Health and Safety Code, Section 1371 or 1371.35, whichever is applicable.

L. CalOptima Health shall not improperly deny, adjust, or contest a claim, and shall provide a clear and accurate written explanation of the specific reasons for the action taken.

M. CalOptima Health may contest or deny a claim, or portion thereof, by notifying the Provider, in writing, that the claim is contested or denied, within thirty (30) calendar days after the date of receipt of the claim by CalOptima Health.

N. CalOptima Health shall not engage in any practices, policies, or procedures that may constitute a basis for a finding of a demonstrable and unjust payment pattern or unfair payment pattern that results in repeated delays in the adjudication and correct reimbursement of a Provider claim.

O. CalOptima Health shall submit all required reports and documents regarding claims payment practices and claims settlement practices to the Department of Managed Health Care (DMHC).

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P. CalOptima Health shall identify and process Overpayment recoveries in accordance with applicable statutory, regulatory and contractual requirements, as well as regulatory guidance, CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination, and Section III.I. of this Policy.

Q. CalOptima Health shall maintain procedures for pre-payment and post-payment claims review, including review of any data associated with Providers, Members, and Covered Services for which payment is claimed.

R. CalOptima Health shall maintain sufficient claims processing, tracking and payment systems capability to comply with applicable State and Federal laws, regulations, and Contract requirements, to determine status of received claims and to estimate incurred and unreported claims amounts.

S. CalOptima Health shall establish and maintain a fair, fast, and cost-effective Provider Dispute process. CalOptima Health shall annually make available to DMHC all records, notes, and documents regarding its Provider Dispute resolution mechanisms and the resolution of its Provider Disputes.

T. CalOptima Health's Claims Administration Department shall inform a Provider in the remittance advice of their right to file a Complaint with CalOptima Health's Grievance and Appeals Resolution Services (GARS) Department, in accordance with CalOptima Health Policy CC.1202: CalOptima Health Provider Complaint.

III. PROCEDURE

A. A Provider shall verify a Member's eligibility to receive Covered Services, in accordance with CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification.

B. For Members assigned to CalOptima Health Community Network (CHCN), a Provider shall obtain authorization for Covered Services, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

C. CalOptima Health and its delegated Health Networks must authorize services through Out-of-Network Providers if the network of CalOptima Health or its Health Networks fail to meet network adequacy requirements. In doing so, Members may utilize any Provider in or out of CalOptima Health's network regardless of Health Network affiliation and in accordance with CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access.

D. CalOptima Health shall make timely and reasonable payment for the following Covered Services provided to a Member by a Non-Contracted Provider:

1. Ambulance services dispatched through 911 or its local equivalent, where other means of transportation may endanger the Member's health, as provided in CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical; and in accordance with Health & Safety Code § 1371.5;

2. Emergency Services and Care - Emergency medical services do not require Prior Authorization. If it is determined that the Member is to be admitted and CalOptima Health or a Health Network does not have a notification of an inpatient admission from the Emergency Room (ER) on file for the room and board charges, CalOptima Health or a Health Network must pay the emergency triage fee and request Medical Records;

3. Urgently needed services;

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4. Authorized post-stabilization care services in accordance with CalOptima Health Policy CC.1600: Authorization and Processing of Referrals.

5. Denied Covered Services that are determined in the Grievance processes in CalOptima Health policies to be services the Member was entitled to have furnished, or paid for, by CalOptima Health or a Health Network; and

6. CalOptima Health or a Health Network shall provide Medically Necessary, Covered Services to a Member through an out-of-network Provider when CalOptima Health or a Health Network is unable to provide the services in the contracted network in accordance with CalOptima Health Policy GG.1539 Authorization for Out-of-Network and Out-of-Area Services.

7. CalOptima Health and its delegated Health Networks must authorize services through Out-of-Network Providers if the network of CalOptima Health or its Health Networks fail to meet network adequacy requirements. In doing so, Members may utilize any Provider in or out of CalOptima Health's network regardless of Health Network affiliation and in accordance with CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access.

E. Payment for Covered Services Rendered by Non-Contracted Providers and Balance Billing Protections

1. Non-Contracted Providers are prohibited from balance billing a CalOptima Health Covered California Member for the following Covered Services:

   a. Non-emergency services when rendered in a Contracting Health Facility in accordance with Health & Safety Code § 1371.9.

   b. Ground ambulance transportation in accordance with Health & Safety Code § 1371.56.

   c. Air ambulance transportation in accordance with Health & Safety Code § 1371.55 and 45 CFR § 149.130 and 45 CFR § 149.440.

2. CalOptima Health Covered California Members shall pay no more than the same cost sharing amount that the Member would pay for the same Covered Services received from a contracted Provider which is referred to as the In-Network Cost-Sharing Amount.

3. CalOptima Health or a Health Network will inform the CalOptima Health Covered California Member and the Non-Contracted Provider of the In-Network Cost-Sharing amount owed by the Member at the time of payment.

4. For non-emergency Covered Services rendered in a Contracting Health Facility, CalOptima Health or a Health Network shall reimburse a Non-Contracted Provider the greater of the Average Contracted Rate (ACR) or one hundred twenty-five percent (125%) of the Medicare reimbursement rate on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered, whichever is greater.

   a. CalOptima Health will determine the Average Contracted Rate using a methodology that shall take into account, at a minimum, information from the independent dispute resolution process, the specialty of the Non-Contracted Provider, and the geographic region in which the services are rendered. The methodology to determine an Average Contracted Rate shall include the highest and lowest contracted rates.

   b. Non-Contracted Providers that dispute the appropriateness of the amount received or paid for

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non-emergency Covered Services subject to Health & Safety Code § 1371.9 may request independent review through DMHC's Independent Dispute Resolution Process (IDRP).

i. Prior to initiating the IDRP, Non-Contracted Providers must participate in CalOptima Health's internal Provider Dispute Resolution process in accordance with CalOptima Health Policy CC.1202: CalOptima Health Provider Complaint.

5. For Covered Services rendered by a non-contracting air ambulance provider, CalOptima Health or a Health Network shall reimburse noncontracted air ambulance providers at the Qualifying Payment Amount (QPA) as specified in the No Suprises Act in 45 CFR § 149.130 and 45 CFR § 149.440, and DMHC (APL) 22-011 No Surprises Act (NSA) Guidance.

6. For Covered Services rendered by a non-contracting ground ambulance provider, CalOptima Health or a Health Network shall reimburse noncontracted ground ambulance providers at the rate established by the local jurisdiction in which the ambulance transport was initiated or, if the transportation was provided on a mutual or automatic aid basis into another jurisdiction, the rate established by the jurisdiction where the provider is based.

a. If the jurisdiction has not established a reimbursement rate, CalOptima Health shall reimburse the provider at the reasonable and customary rate for the services as determined under California Code of Regulations, Title 28, section 1300.71(a)(3)(B) and in accordance with DMHC (APL) 24-010 Noncontracted ground ambulance services.

F. Claims Submission

1. A Provider shall utilize the following standard forms for submitting claims for Covered Services:

a. A Provider shall use the CMS-1500 (Attachment A) when submitting a claim for professional services;

b. A Provider shall use the UB-04 Form (Attachment C) when submitting a claim for hospital inpatient or outpatient services.

2. A Provider shall submit a claim on the appropriate form with supporting documentation, including required prior authorizations.

3. A Provider may submit invoices, electronic or paper claims to CalOptima Health for Covered Services.

a. A Provider may elect to submit electronic claims to CalOptima Health utilizing the process outlined in the CalOptima Health Provider Manual, Section H3: Electronic Claim Submissions: CalOptima Health Direct, Shared risk and OneCare (HMO D-SNP) Claims. This is located on the Provider section of the CalOptima Health website.

b. A Provider who submits a paper claim shall submit the original claim form and retain a copy for the Provider's files. CalOptima Health shall not accept carbon copies, photocopies, computer generated copies, or facsimiles of paper claims.

c. A Provider may submit paper claims to CalOptima Health by mail, or in person, at the following addresses:

i. By mail:
Attn Claims Department

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CalOptima Health
Post Office Box 11037
Orange CA 92856

ii. In person:
Claims Department
CalOptima Health
505 City Parkway West
Orange CA 92868

4. A Provider shall bill accordingly for services rendered based on bill type and specialty. Claims elements include but are not limited to the following:

a. Member Information;

b. Provider of Service;

c. Date of Service;

d. Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS);

e. Applicable Revenue code (Institutional only);

f. Applicable modifier (information and/or financial when required);

g. Place of Service;

h. Service Units; and

i. Billed Charges.

G. Claim Filing Deadlines

1. A contracted Provider shall submit a claim for Covered Services within ninety (90) calendar days and a Non-Contracted Provider shall submit a claim for Covered Services within one hundred eighty (180) calendar days after the date of service.

2. If CalOptima Health is not the primary payer under coordination of benefits, CalOptima Health shall not impose a deadline for submitting supplemental or coordination of benefits claims to CalOptima Health that is less than ninety (90) calendar days from the date of payment or date of contest, date of denial, or notice from the primary payer.

H. Misdirected Claims

1. For a Provider claim involving Emergency Services and Care that is incorrectly sent to CalOptima Health, CalOptima Health shall forward the claim to the appropriate Health Network within ten (10) working days after receipt of the claim.

2. For a Provider Claim that does not involve Emergency Services and Care that is incorrectly sent to CalOptima Health, and the Provider that filed the claim is a participating Provider, CalOptima Health shall either:

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a. Send the Provider a notice of denial via a remittance advice, within ten (10) working days, with instructions to bill the Health Network; or

b. Forward the claim to the appropriate Health Network, within ten (10) working days of the receipt of the claim.

3. In all other cases, for claims incorrectly sent to CalOptima Health, CalOptima Health shall forward the claim to the appropriate Health Network within ten (10) working days of the receipt of the claim.

I. Interest on Late Claims

1. Interest shall begin to accrue on the thirty-first (31st) calendar day following receipt of the claim and is calculated based on calendar days.

2. CalOptima Health shall automatically include for late payment on a Complete Claim for Emergency Services and Care the greater of fifteen dollars ($15) for each twelve (12) month period or portion thereof, on a non-prorated basis, or interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.

3. CalOptima Health shall automatically include for late payments on all other claims other than Complete Claims for Emergency Services and Care, interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.

4. If the interest due on an individual claim is less than two dollars ($2), CalOptima Health may wait until the close of the calendar month and make a lump interest payment for all late claim payments during that time period. CalOptima Health shall make lump interest payments within ten (10) calendar days of the calendar month's end.

5. If CalOptima Health fails to automatically include the interest due on a late claim payment, CalOptima Health shall pay the Provider a ten dollar ($10) penalty for that late claim, in addition to any interest amount due.

J. Denying, Adjusting, or Contesting a Claim

1. CalOptima Health may reasonably contest a claim if CalOptima Health has not received the completed claim and all Information Necessary to Determine Payer Liability for the claim, or has not been granted reasonable access to information concerning provider services. Information Necessary to Determine Payer Liability for the claim includes, but is not limited to, reports of investigations concerning Fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for CalOptima Health to determine the Medical Necessity for the health care services provided.

2. CalOptima Health shall not contest a claim that is consistent with the procedure or revenue codes and services approved by prior authorization with appropriate documentation included on the claim.

3. CalOptima Health may contest or deny a claim, or portion thereof, by notifying the Provider, in writing, that the claim is contested or denied, within thirty (30) calendar days after the date of receipt of the claim by CalOptima Health. .

a. If CalOptima Health contests a portion of the claim, it must reimburse any uncontested portions of the claim within statutory timeframes.

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4. In the event that CalOptima Health requests Reasonably Relevant Information from a Provider; in addition to information that the Provider submits with a claim, CalOptima Health shall provide a clear, accurate, and written explanation of the necessity for the request. CalOptima Health is prohibited from requesting irrelevant or unnecessary information from Providers during claims processing.

5. If CalOptima Health fails to provide the Provider with timely written notice that a claim has been contested or denied, or requests information that is not reasonably necessary to determine payer liability but ultimately pays the claim in whole or in part, CalOptima Health shall compute the interest or impose a penalty, pursuant to Section III.I. of this Policy.

6. A request for Information Necessary to Determine Payer Liability from a third party shall not extend the time for reimbursement or the time for contesting or denying claims. CalOptima Health shall either contest or deny, in writing and within the time frames set forth in Section III.J. of this Policy, incomplete claims and claims for which Information Necessary to Determine Payer Liability that has been requested, which are held or pended awaiting receipt of additional information. CalOptima Health shall identify in the denied or Contested Claim, the individual or entity that was requested to submit information, the specific documents requested, and the reason(s) why the information is necessary to determine payer liability.

7. If CalOptima Health subsequently denies the claim based on the Provider's failure to provide the requested medical records or other information, any Provider Dispute arising from the denial of such claim shall be handled in accordance with Title 28, California Code of Regulations, Section 1300.71.38.

8. Any claim submitted by a Provider that is flagged as "Do Not Pay" in the Provider Data Systems database will be denied.

   a. A "Do Not Pay" flag is entered into the Provider Data System for:

      i. Excluded Network Providers or Subcontractors for services provided after the effective date of a suspension or exclusion.

      ii. Network Providers or Subcontractors for services on payment suspensions until payment suspension or exclusion has been lifted.

K. Reimbursement for the Overpayment of Claims

1. Overpayment Identified by CalOptima Health

   a. If CalOptima Health determines that it has overpaid a claim, it shall notify the Provider, in writing, through a separate notice clearly identifying the claim, the name of the patient, the date of service and include a clear explanation of the basis upon which CalOptima Health believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim. The notice shall also include the following:

      i. Inform the provider how to access CalOptima Health's Dispute resolution mechanism offered pursuant to Health & Safety Code § 1367(h);

      ii. The name and address to which the Dispute should be submitted and a statement that Health & Safety Code § 1371.1 requires a Provider to reimburse CalOptima Health for an Overpayment within thirty (30) working days of receipt by the Provider of the notice of Overpayment unless the Provider contests the Overpayment within thirty (30)

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working days; and

iii. A statement that if the Provider does not make reimbursement of an uncontested Overpayment within thirty (30) working days after receipt of the notice, interest shall accrue at a rate of ten (10) percent per annum.

b. If the Provider contests CalOptima Health's notice of reimbursement of the Overpayment of a claim, the Provider, within thirty (30) working days of the receipt of the notice of Overpayment of a claim, shall send written notice to CalOptima Health's GARS Department stating the basis upon which the Provider believes that CalOptima Health's notice was in error. CalOptima Health shall receive and process the contested notice of Overpayment of a claim as a Provider Dispute, in accordance with CalOptima Health Policy CC.1202: CalOptima Health Provider Complaint.

c. If the Provider does not contest CalOptima Health's notice of reimbursement of the Overpayment of a claim, the Provider shall reimburse CalOptima Health within thirty (30) working days of the receipt, by the Provider, of the notice of Overpayment of a claim..

d. If the Provider does not reimburse CalOptima Health for the Overpayment of a claim within thirty (30) working days after receipt of CalOptima Health's notice, interest shall accrue at the rate of ten percent (10%) per annum, beginning with the first (1st) calendar day after the thirty (30) working day period.

e. CalOptima Health may only offset an uncontested notice of reimbursement of the Overpayment of a claim against a Provider's current claim submission when:

i. The Provider fails to reimburse CalOptima Health within the time frame set forth in Section III.I.1. of this Policy; and

ii. The Provider has entered into a written contract specifically authorizing CalOptima Health to offset an uncontested notice of Overpayment of a claim from the current claim submissions.

f. In the event that an Overpayment of a claim or claims is offset against a Provider's current claim or claims pursuant to this section, CalOptima Health shall provide the Provider a detailed written explanation identifying the specific Overpayment or payments that have been offset against the specific current claim or claims.

2. CalOptima Health shall investigate any identified Overpayments that are suspected to be the result of inappropriate and/or inaccurate billing activity and shall promptly refer such identified suspected Overpayment to CalOptima Health's Special Investigations Unit (SIU) and Covered California, if applicable, in accordance with CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination.

3. CalOptima Health shall provide effective training and education for its compliance officer and all employees. This training shall include reporting to Covered California, if applicable, when Overpayments are identified or recovered, specifying which Overpayments are due to potential Fraud, in accordance with CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination, CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting, and CalOptima Health Policy HH.1105: Fraud Waste, and Abuse Detection.

L. CalOptima Health shall retain claims information data for a period of at least ten (10) years after the termination of its contract with Covered California and shall not remove or transfer such records and data from its offices, except in accordance with applicable laws.

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M. CalOptima Health shall hold harmless and indemnify Members for CalOptima Health's debt to Providers for Covered Services rendered and billed to Members.

N. CalOptima Health shall 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 estimate Incurred But Not Reported (IBNR) claims.

IV. ATTACHMENT(S)

A. CMS-1500
B. Provider Claims Dispute Resolution Request Form
C. UB-04 Form

V. REFERENCE(S)

A. CalOptima Health Contract with Covered California
B. CalOptima Health Policy CC.1202: CalOptima Health Provider Complaint
C. CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification
D. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible
E. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
F. CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination
G. CalOptima Health Provider Manual
H. Department of Managed Health Care (DMHC) All Plan Letter (APL): 22-011 No Surprises Act (NSA) Guidance
I. Department of Managed Health Care (DMHC) All Plan Letter (APL): 24-010 Noncontracted Ground Ambulance Services
J. Health & Safety Code, §§1371 through 1371.39
K. Title 28, California Code of Regulations, §§ 1300.71 and 1300.71.38
L. Title 42, Code of Federal Regulations (CFR), § 149.130 and 149.440

VI. REGULATORY AGENCY APPROVAL(S)

None To Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1001	Claims Processing for Covered Services for which CalOptima Health is Financially Responsible	Covered California

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IX. GLOSSARY

Term	Definition
Abuse	Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services.
Average Contracted Rate	The average of the contracted commercial rates paid by the health plan or delegated entity for the same or similar services in the geographic region.
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Contracting Health Facility	Contracting Health Facility means a health facility that is contracted with CalOptima Health to provide Covered Services. A Contracting Health Facility includes, but is not limited to, the following providers: 1. A licensed hospital. 2. An ambulatory surgery or other outpatient setting, as described in subdivision (a), (d), (e), (g), or (h) of Health & Safety Code § 1248.1. 3. A laboratory. 4. A radiology or imaging center.
Complete Claim	A claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides Reasonably Relevant Information and Information Necessary to Determine Payer Liability as defined in Title 28, California Code of Regulations section 1300.71 (a)(10) and (a)(11).
Contested Claim	A claim, or portion thereof, is reasonably contested if CalOptima Health has not received the completed claim and all information necessary to determine payer liability for the claim or has not been granted reasonable access to information concerning provider services. Information necessary to determine payer liability for the claim includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for CalOptima Health to determine the medical necessity for the health care services provided.
Covered Services	Health care services that are covered benefits under CalOptima Health's contract with Covered California as further described in the Evidence of Coverage and supporting documents.
Denied Claim	Non-approval of a requested care or service. This includes any partial approvals and denials, modifications, or delays to the original request.
Dispute	A claims payment dispute regarding an amount paid that is less than the expected rate.
Emergency Services and Care	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 and Health & Safety Code § 1317.1(a)(1) and §1317(a)(2)(A)

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Term	Definition
Fraud	Consists of an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury. (CA Civil Code §3294 (c)(3), CA Penal Code §§470-483.5). Prevention and early detection of fraudulent activities is crucial to ensuring affordable healthcare for all individuals. Examples of fraud include false applications to obtain payment, false information to obtain insurance, billing for services that were not rendered. Fraud includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit, in accordance with Health and Safety Code section 1348.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a health maintenance organization (HMO), subcontractor, or first tier entity, that contracts with CalOptima Health to provide Covered Services to members.
Incurred But Not Reported (IBNR)	Refers to an unpaid claim liability or claim reserve established by the health plan for healthcare services that have been rendered by the provider but not yet paid by the plan. This is also referred to as Incurred But Not Paid (IBNP).
Information Necessary to Determine Payer Liability	The minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.
Member	An individual enrolled in a CalOptima Health program.
Network Provider	Any Provider or entity that CalOptima Health has contracted with to deliver Covered Services for a specific network service area as defined in 28 CCR 1300.67.2.2(b)(10)
Non-Contracted Provider	A Provider who is not contracted with CalOptima Health to provide services under the Member's CalOptima Health plan contract.
Overpayment	Any payment made by CalOptima Health to a Provider to which the Provider is not entitled to under Health & Safety Code § 1371.1..
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services.
Provider Complaint	The general term used to identify all provider filed request for review, and expressions of, dissatisfaction with any aspect of CalOptima Health or its Health Networks. This includes appeals, disputes and grievances.
Reasonably Relevant Information	The minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.
Subcontractor	An individual or entity that has an agreement with CalOptima Health that relates directly or indirectly to the performance of CalOptima Health's services under this Agreement. A provider is not a Subcontractor solely because it enters into a provider agreement.

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Term	Definition
Waste	Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls.

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

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Provider Claims Dispute Request Form

This form is for all providers disputing a claim with CalOptima Health. For additional information and requirements regarding provider claim disputes, please refer to Policies HH.1101, MA.9006 and MA.9009 found under the Providers section of www.caloptima.org.

Please return this completed form and any supporting documentation to CalOptima Health by mailing them to:

Grievance and Appeals Resolution Services
505 City Parkway West
Orange, CA 92868

PLEASE NOTE:

This form is for claim payment disputes related to reimbursement rates or processing. This form is **NOT** intended for requests related to clinical reviews for medical necessity determinations in the case of a denied authorization or retrospective review request. A separate form must be completed for each member, and all information must be included, i.e., claim number, member client index number (CIN) and date of service.

To request a service authorization dispute (medical necessity) please complete the provider service authorization dispute request form, which can be found at www.caloptima.org.

For routine follow-up regarding **claims or PDR status**, please contact the CalOptima Health Claims Provider Line at **714-246-8600**.

PROVIDER QUESTIONNAIRE

1) Have you received a payment remittance (paper or electronic) for this claim? ☐ YES ☐ NO
2) If you answered "NO" to question 1, please call the appropriate network to check on the claim status.
3) If you answered "YES" to question 1, are you disputing the outcome of the claim adjudication or the payment dispute?
   ☐ Claims adjudication ☐ Payment dispute
4) If you answered "Claims adjudication" to question 3 and the health network is not CalOptima Health Community Network (CCN) or CalOptima Health Direct (COD), please **do not** complete this form. You must submit a payment dispute to the appropriate health network prior to submitting your request to CalOptima Health. If you answered, "Payment dispute," please include the Level 1 decision and complete this form. If the health network is CCN or COD, please complete this form.
5) Please check the application box below:
   ☐ Contracted provider ☐ Non-contracted provider (Waiver of Liability [WOL] required for OneCare)

Please select the applicable health network below:	
☐ AltaMed Health Services	☐ Kaiser Permanente
☐ AMVI Care Medical Group	☐ Noble Mid-Orange County
☐	☐ Prospect Medical Group
☐ CHOC Health Alliance	☐ Optum Care Network
☐ CCN or COD	☐ United Medical Care Group
☐ Family Choice Health Services	☐ Vision Services Plan (VSP)
☐ Family Choice Medical Group	
☐ HPN – Regal Medical Group	

SECTION 1: Claim Dispute

Processing Time: 45 Business Days

Claim/EDI Tracking Number(s):		Member ID #:	
Member Name		Date(s) of Service:	
Provider Name:		Billed Charges:	Contact Person:
Provider ID (TIN):	NPI:	Provider Phone #: ( )	Provider Fax #: ( )

Type of Claim Dispute

Based upon the following reasons, the provider requests reconsideration of this claim.
Providers: Please check applicable reasons and attach all supporting documentation.

☐ **Member:** Processed under incorrect member	☐ **Provider:** Processed under incorrect provider/tax ID
☐ **Coding/Bundling Edits:** Attach supporting documentation/medical records (Documentation is required)	☐ **Timely Filing:** Attach claims and supporting documentation showing claim was filed in a timely manner
☐ **Coordination of Benefits Information:** COB–related adjustment primary insurance	☐ **Payment Amount:** _____ ☐ **Claims Reversal Needed:** Reason: _____
☐ **Service Is Not a Duplicate:** Rationale (Documentation is required):	☐ **Under/Overpayment:** Rationale (Documentation is required):
☐ **Authorization Approved:** Include Notice of Approval (NOA) or other notification of approval.	**Comment/Other:**

1	2	3a PAT. CNTL #	
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

31 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38		39 VALUE CODES CODE	AMOUNT		41 VALUE CODES CODE	AMOUNT
		a				
		b				
		c				
		d				

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		*PAGE ____ OF ____*		*CREATION DATE*					23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67 I	A J	B K	C L	D M	E N	F O	G P	H Q	68

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI				73

74 PRINCIPAL PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75	76 ATTENDING	NPI	QUAL	
					LAST		FIRST	
d. OTHER PROCEDURE CODE	DATE				77 OPERATING	NPI	QUAL	
					LAST		FIRST	
80 REMARKS		81CC a			78 OTHER	NPI	QUAL	
		b			LAST		FIRST	
		c			79 OTHER	NPI	QUAL	
		d			LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO.

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Policy:	CC.1300
Title:	**Block Transfers**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2027
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☒ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy addresses the process by which CalOptima Health notifies Members, the Department of Managed Health Care (DMHC), and Covered California of a termination of a contract with a Provider Group or general acute care hospital requiring a Block Transfer filing.

II. POLICY

CalOptima Health will comply with all requirements applicable to Block Transfers and will submit a filing to DMHC when a Block Transfer is triggered by a Provider Contract termination.

III. PROCEDURE

A. In the event of a termination of a contract with a Provider Group or general acute care hospital, CalOptima Health shall submit a Block Transfer filing to the DMHC at least seventy-five (75) calendar days before the termination date of the contract.

B. The filing shall include a copy of the written notice CalOptima Health proposes to send to Affected Members. The Member Transfer Notice shall include:

1. The name of the Terminated Provider Group or Terminated Hospital, and the name of the assigned physician, if applicable.

2. A brief explanation of why the transfer to an alternate provider, or redirection to an Alternate Hospital for future hospital-based services, is necessary due to the termination of the contract between CalOptima Health and the Terminated Provider.

3. The date of the pending contract termination and transfer.

4. An explanation to the Affected Member outlining the Affected Member's assignment to a new Provider Group, options for selecting a physician within a new Provider Group, and applicable timeframes to make a new Provider Group selection in accordance with CalOptima Health Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider. The explanation shall include a notification to the Affected Member that he or she may select a

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different network provider by contacting CalOptima Health as outlined in CalOptima Health's written continuity of care policy and evidence of coverage or disclosure form.

5. A statement that CalOptima Health will send the Affected Member a new member information card with the name and telephone number of the Receiving Provider Group and assigned physician by a specified later date, which will occur prior to the date of the contract termination. Alternatively, CalOptima Health may notify the Affected Member of the name, address and telephone number of the Receiving Provider Group and assigned physician, or Alternate Hospital, to which the Affected Member will be assigned or redirected in the absence of a selection made by the Member.

6. A statement that the Affected Member may contact CalOptima Health's customer service department to request continuity of care for an ongoing course of treatment from a Terminated Provider. This statement may include either a statement outlining the specific conditions set forth in California Health and Safety Code § 1373.96(c), or an explanation to the Affected Enrollee that his or her eligibility is conditioned upon certain factors as outlined in CalOptima Health's written continuity of care policy and evidence of coverage or disclosure form.

7. The telephone number through which the Affected Member may contact CalOptima Health for a further explanation of his or her rights to completion of care, including CalOptima Health's written continuity of care policy, and a link that an Affected Member may use to obtain a downloadable copy of the policy from the CalOptima Health website.

8. The following statement in at least eight (12)-point font:

   a. "If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact CalOptima Health's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov."

C. Member Transfer Notices and any other notice required by this policy shall comply with all applicable language assistance statutes and regulations, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

D. CalOptima Health shall not send the Member Transfer Notice to Members until the DMHC has reviewed and approved the notice, or unless the notice is deemed approved. The notice is deemed approved if the DMHC does not respond within seven (7) days of the date of receipt of the Block Transfer filing.

E. At least sixty (60) days before the termination date of a contract between CalOptima Health and a Provider Group or a general acute care hospital, CalOptima Health shall send the Member Transfer Notice by United States mail to Members who are assigned to the Terminated Provider Group or Terminated Hospital, unless CalOptima Health has applied for and been granted a waiver from DMHC, or the waiver is deemed approved. The waiver is deemed approved if the DMHC does not respond within seven (7) days of the date of the receipt of the waiver application.

F. CalOptima Health shall provide Covered California with copies of the written notices that will be sent to Affected Members prior to mailing the notices.

G. CalOptima Health shall send the Member Transfer Notice to Affected Members as follows:

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1. For Affected Members who are block transferred from a Terminated Provider Group, CalOptima Health shall send the notice to all Affected Members assigned to the Terminated Provider Group.

2. For Affected Members who are block transferred from a Terminated Hospital, CalOptima Health shall send the notice to all Affected Members who reside within fifteen (15) miles of the Terminated Hospital.

3. If the Terminated Provider is a hospital and CalOptima Health assigns Members to a Provider Group with exclusive admitting privileges to the hospital, CalOptima Health shall send the written notice to each Member who is a member of the Provider Group and who resides within a fifteen (15)-mile radius of the Terminated Hospital.

4. If CalOptima Health assigns Members to a Provider Group with admitting privileges to hospitals in the same geographic area as the Terminated Hospital, CalOptima Health shall send the written notice to all Members who reside within a fifteen (15)-mile radius of the Terminated Hospital.

H. In the event that an individual provider terminates the provider's contract or employment with a Provider Group that contracts with CalOptima Health, the Provider Group shall be responsible for sending the Member notice in accordance with this policy.

1. All contracted provider communications to Affected Members shall include the same information required by this policy for Member Transfer Notices regarding termination of a provider or a Block Transfer and in accordance with language access and assistance requirements.

I. If, after sending the Member Transfer Notices, CalOptima Health reaches an agreement with a Terminated Provider to renew or enter into a new Provider Contract or to not terminate the Provider Contract, CalOptima Health shall promptly inform the DMHC and provide an additional notification, either by telephone or in writing, to each Affected Member. The notice shall include:

1. A brief explanation of the fact that CalOptima Health has reached an agreement with the Affected Member's previously assigned provider.

2. An explanation to the Affected Member regarding options for either returning to the previously assigned provider, keeping the newly assigned provider, or selecting another Participating Provider from CalOptima Health's contracting provider list.

3. An explanation to the Affected Member of the procedure by which the Member may contact CalOptima Health to express his or her desire to return to the previously assigned provider.

4. If the additional Member notice is given in writing, then the notice must include the following statement in at least twelve (12)-point font:

a. "If you have any questions regarding this notice please contact [Plan Name] customer service department. If you have further concerns about your provider network, you are encouraged to contact the Department of Managed Health Care by telephone at its toll-free number 1-888-HMO-2219, or at TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov."

J. If an Affected Member does not exercise the option to return to their previously assigned provider, CalOptima Health shall reassign the Member to another provider if it has not already done so.

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K. CalOptima Health and a provider shall include in all written, printed, or electronic communications sent to a Member that concern a contract termination, including a Block Transfer, the following statement in not less than twelve (12)-point type:

1. "If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact your health plan's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects consumers, by telephone at its toll-free number, 1-888-466-2219, or at a TDD number for the hearing and speech impaired at 1-877-688-9891, or online at www.dmhc.ca.gov."

L. In the event of a Block Transfer, CalOptima Health shall, and shall require Participating Providers to, cooperate with Covered California in planning for the orderly transfer of Members as necessary and as required under applicable laws, rules and regulations, including those relating to continuity of care.

M. For a Terminated Hospital contract, CalOptima Health shall also submit to the DMHC as part of its Block Transfer filing the following information:

1. A brief explanation of the cause of the hospital redirection, including whether the contract termination or non-renewal was initiated by CalOptima Health, the hospital, or by a contracting Provider Group.

2. A copy of the notice of termination sent or received by CalOptima Health.

3. If the contract termination will affect fifty thousand (50,000) or more Members, the relevant portions of the Provider Contract(s) that relate to continuity of care and transition of care

4. Either of the following two options:

   a. A list of counties in which Affected Members reside and the corresponding number of Affected Members for each county; or

   b. A list of the zip codes in which Affected Members reside and the corresponding number of Affected Members for each zip code.

5. The number of Affected Members assigned to the Terminated Hospital, and the number to be reassigned to each Alternate Hospital, classified by type of product (for example, commercial, Medi-Cal, Healthy Families, etc.).

6. The number of Affected Members within a fifteen (15)-mile radius of the Terminated Hospital.

7. The date CalOptima Health anticipates it will mail the Member Transfer Notice.

8. The proposed date or dates of transfer of Affected Members, or, if CalOptima Health intends to transfer Affected Members on various dates, the reason for the different transfer dates.

9. If additional governmental departments or agencies require approval of Member notices regarding the Block Transfer, provide copies of each proposed notice as well as an explanation of the status of each required approval.

10. The identity of the Terminated Hospital and Alternate Hospital, including the contract renewal or termination date for each Alternate Hospital.

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11. A listing identifying any services that are available at the Terminated Hospital that are not available at an Alternate Hospital, including the arrangements CalOptima Health has made to ensure Affected Members have an opportunity to receive those services.

12. Based upon the data made public on the Office of Statewide Health Planning and Development's website, for each of the proposed Alternate Hospitals, the available bed occupancy rate for the most recently completed calendar year, and, if the rate is at 80% or higher, the justification as to the sufficiency of the Alternate Hospital's capacity to serve additional Members.

13. The number of bed days utilized by Members at the Terminated Hospital for the most recently completed calendar year.

14. An analysis showing the driving distance between the proposed Alternate Hospital and the Terminated Hospital.

15. Of the primary care providers to whom Affected Members are currently assigned, the number and percentage of primary care providers with active admitting privileges at the Alternate Hospital(s) and the number of Affected Members assigned to these primary care providers and the number and percentage of primary care providers without active admitting privileges at the Alternate Hospital(s) and the number of Affected Members assigned to these primary care providers.

16. The procedure by which an Affected Member who is assigned to a primary care provider who does not have active admitting privileges to the Alternate Hospital(s) will receive needed hospital care.

17. Of the specialists available to Affected Members with active admitting privileges at the Terminated Hospital, the number and percentage with active admitting privileges at the Alternate Hospital(s), and, if any of these specialists will be unable to admit to the Alternate Hospital(s), the specialty involved, how many specialists of that specialty, if any, will still be available to admit at the Alternate Hospital(s), and how Affected Members will receive care for that specialty at a proposed Alternate Hospital if there are an insufficient number of remaining specialists with active admitting privileges.

18. Confirmation that CalOptima Health's continuity of care program, as filed with the DMHC, will be implemented for any Affected Members.

N. For a Provider Group contract termination, CalOptima Health shall also submit to the DMHC as part of its Block Transfer filing the following information:

1. A brief explanation of the cause or circumstances of the Provider Contract termination or non-renewal, including whether the contract termination or non-renewal was initiated by CalOptima Health or the Provider Group. If the Provider Contract termination is due to a provider closure, CalOptima Health shall specify whether the provider closure is due to bankruptcy, insolvency, sale, ceasing business operations, or the closure of a specific office site.

2. A copy of the notice of termination sent or received by CalOptima Health.

3. If the contract termination will affect fifty thousand (50,000) or more Members, the relevant portions of the Provider Contract(s) that relate to continuity of care and transition of care.

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4. Either of the following two options:

   a. A list of counties in which Affected Members reside and the corresponding number of Affected Members for each county; or

   b. A list of the zip codes in which Affected Members reside and the corresponding number of Affected Members for each zip code.

5. A listing, classified by type of product (for example, commercial, Medi-Cal, Healthy Families, etc.) that specifies the number of Affected Members assigned to the Terminated Provider.

6. The date CalOptima Health anticipates it will mail the Member Transfer Notice.

7. The proposed date or dates of transfer. If CalOptima Health intends to transfer Affected Members on various dates, it shall explain the reason for the different transfer dates.

8. CalOptima Health's estimate of the percentage of Affected Members who will remain with the same primary care provider after the transfer to a Receiving Provider Group.

9. A matrix of proposed Receiving Provider Groups that includes the following information:

   a. The identity of the Receiving Provider Group(s), including its risk bearing organization number as assigned by the Department.

   b. The number of Affected Members being transferred to each Receiving Provider Group listed by type of product. If CalOptima Health gives the Affected Members the choice of selecting a new provider, CalOptima Health shall also provide the number of Affected Members to be transferred to each receiving Provider Group by default if no selections are made by the Affected Members.

   c. A listing of all hospitals to which Receiving Provider Groups refer Affected Members, if different from the Terminated Provider Group.

10. Confirmation that CalOptima Health's continuity of care program, as filed with the DMHC, will be implemented for any Affected Members.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Health and Safety Code § 1373.65
B. CalOptima Health Contract with Covered California
C. CalOptima Health Policy DD.2002: Linguistic and Cultural Services
D. CalOptima Health Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider
E. DMHC All Plan Letter (APL) 19-013: (OPM) - Block Transfer Enrollee Transfer Notices
F. DMHC All Plan Letter (APL) 21-015: Office of Plan Monitoring – Block Transfer Portal Updates
G. Title 28, California Code of Regulations, § 1300.67.1.3

VI. REGULATORY AGENCY APPROVAL(S)

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None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1300	Block Transfers	Covered California

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IX. GLOSSARY

Term	Definition
Affected Member	For purposes of this policy, a CalOptima Health Member who is assigned to a Terminated Provider Group or a Terminated Hospital.
Alternate Hospital	A hospital that will provide services to CalOptima Health Members in place of a Terminated Hospital.
Block Transfer	A transfer or redirection of two thousand (2,000) or more Members from a Terminated Provider Group or Terminated Hospital to one or more contracting providers that takes place as a result of the termination or non-renewal of a Provider contract.
Covered Services	Health care services that are covered benefits under CalOptima Health's contract with Covered California as further described in the Evidence of Coverage and supporting documents.
Member	An individual enrolled in a CalOptima Health program.
Member Transfer Notice	A written notice that is sent to Members who are assigned to a Terminated Provider.
Participating Provider	An individual health care professional, hospital, clinic, facility, entity, or any other person or organization that provides Covered Services and that, at the time care is rendered to a Member, has (or is a member of a Provider Group that has) a contract in effect with CalOptima Health to provide Covered Services to Enrollees and accept copayments for Covered Services.
Provider Contract	A contract between CalOptima Health and one or more health care providers, through which CalOptima Health arranges to provide health care services for Members.
Provider Group	A group of physicians or other health care professionals that is clinically integrated, financially integrated, or that contract together to provide care to patients in a coordinated manner.
Receiving Provider Group	A Provider Group that will provide services to Affected Members in place of the Terminated Provider Group.
Terminated Hospital	A general acute care hospital that will no longer maintain a Provider Contract with CalOptima Health following the termination or non-renewal of a Provider Contract.
Terminated Provider	A Terminated Provider Group or a Terminated Hospital.
Terminated Provider Group	A Provider Group that will no longer maintain a Provider Contract with CalOptima Health following the termination or non-renewal of a Provider Contract.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contact

Linda Lee, Executive Director, Quality, (657) 900-1069

Recommended Actions

Approve New CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access, effective January 1, 2027, in accordance with Covered California regulatory requirements for the Department of Managed Health Care filing.

Background

On August 1, 2024, the CalOptima Health Board of Directors (Board) authorized the Chief Executive Officer (CEO) to convene a stakeholder steering committee composed of key external partners and providers to discuss considerations for potential participation in Covered California. CalOptima Health leadership and staff convened the Covered California Stakeholder Steering Committee, which has met on nine separate occasions. On October 3, 2024, the Board directed the CEO to request the Orange County Board of Supervisors (BOS) to amend CalOptima Health's governing ordinance to remove the prohibition on participation in Covered California. On January 14, 2025, the BOS unanimously voted to amend the ordinance to allow CalOptima Health's participation in Covered California. On December 5, 2024, the Board approved actions related to Covered California consulting support contracts and associated funding.

CalOptima Health must obtain approval to operate a Covered California product under its Knox-Keene Act license from the California Department of Managed Health Care (DMHC). Obtaining a Knox-Keene Act license or expanding an existing license is a regulatory filing process that all plans must comply with to offer an individual market health plan. While CalOptima Health is currently licensed with DMHC for the OneCare Medicare product, CalOptima Health must submit a filing to expand its current Knox-Keene Act license to participate in the individual market. As a first step in this process, CalOptima Health participated in a pre-filing conference with DMHC on February 25, 2025.

Discussion

The DMHC filing process is a multi-phased process that CalOptima Health must complete by early 2026 to obtain the proper approvals to operate an individual market health plan. The process requires the submission of at least 89 supporting exhibits that demonstrate compliance with the requirements of the Knox-Keene Act.

Several of the documents that must be submitted to DMHC are policies and procedures that demonstrate compliance with statutory and regulatory requirements. Staff has evaluated the policies and procedures

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that are needed to demonstrate compliance. In the area of quality, staff recommends approval of a new policy and procedure to demonstrate compliance with timely access standards.

Policies & Procedures Summary – Timely Access

The DMHC filing requires submission of a description of standards with respect to accessibility and a policy and procedures for monitoring the accessibility of services. To demonstrate compliance with these requirements, staff proposes new Policy CC.1700: Standards of Accessibility and Timely Access.

This new policy is developed to demonstrate compliance with DMHC requirements regarding:

- Access and availability standards;
- Network adequacy, including timely access, and access to care;
- Monitoring process and correcting network deficiencies;
- Alternative access standard requests or access to out-of-network care; and
- Reporting significant network disruptions to Covered California.

To meet the timely access requirements, staff drafted Policy CC.1700: Standards of Accessibility and Timely Access to establish requirements for required access and availability standards. The policy outlines the process for monitoring network adequacy, timely access, and access to care, including processes correcting network deficiencies, applying alternative access standards when necessary, and processes for state and federal reporting.

This new policy demonstrates compliance with the following statutory requirements and DMHC guidance:

- California Health & Safety Code §§ 1367, 1375.9;
- California Code of Regulations, Title 28 §§ 1300.51, 1300.67.2, 1300.70;
- DMHC All-Plan-Letter (APL) 24-021: Network Adequacy Standards and Methodology;
- DMHC APL 24-019: Network Submission Instruction Manual and Annual Network Report Forms for Reporting Year 2025; and
- DMHC APL 22-030: Requirement for Plans to “Arrange for” Covered Services.

Staff seeks Board approval of the attached new policy, effective January 1, 2027.

Fiscal Impact

The recommended action is operational in nature. The anticipated costs will be included in future Covered California operating budgets.

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Rationale for Recommendation

Approval of CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access will support CalOptima Health's application to expand its Knox-Keene Act license to operate an individual market plan.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Attachment 1: CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access

/s/ Michael Hunn *05/29/2025*

Authorized Signature **Date**

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Policy:	CC.1700
Title:	**Standards of Accessibility and Timely Access**
Department:	Medical Management
Section:	Quality Analytics
CEO Approval:	*/s/*
Effective Date:	01/01/2027
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☒ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy establishes required access and availability standards, including Provider Network Adequacy, for CalOptima Health Members to obtain effective, appropriate, and timely access to care and describes the process CalOptima Health uses for monitoring Network Adequacy, timely access, and access to care, including processes correcting Network deficiencies, applying for Alternative Access Standards when necessary, and ensuring Health Networks comply with access standards and timely access requirements. This policy also describes how CalOptima Health educates Members about access to and availability of services and CalOptima Health's processes for state and federal reporting.

II. POLICY

A. General Access

1. CalOptima Health shall ensure all Covered Services are readily available and accessible to CalOptima Health Members in a timely manner appropriate for the nature of the Member's condition consistent with good professional practice. CalOptima Health shall establish and maintain Networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

2. CalOptima Health shall meet all access requirements and Network Adequacy standards in compliance with state and federal laws and regulations and its Contract with Covered California.

    a. For Network Provider types not specified in the Department of Managed Health Care's (DMHC) Specialist Physician Geographic Access Standards and Methodology or Counseling Non-Physician Mental Health Professional Geographic Access Standards and Methodology documents, CalOptima Health shall ensure these Providers are within reasonable proximity to Members, and so located as to not result in unreasonable barriers to accessibility.

3. CalOptima Health shall evaluate CalOptima Health's and a Health Network's compliance with the standards outlined in this policy.

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4. Anti-discrimination: CalOptima Health and its Health Networks shall not discriminate against Members on the basis of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, language, gender identity, identification with any other persons or groups defined in Penal Code, Section 422.56, health status, or physical or mental disability.

5. Access for Members with physical or mental disabilities: CalOptima Health and its Health Networks shall provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities.

    a. If a Provider cannot meet the minimum access standards for disabled Members, CalOptima Health and its Health Networks shall coordinate a referral to a Provider with the appropriate access standards.

    b. CalOptima Health and its Health Networks shall ensure that Providers offer flexibility in scheduling Covered Services for Members with disabilities.

6. Hours of operation: Hours of operation and provision for after-hour services shall be reasonable; and the CalOptima Health Network shall include unscheduled urgent services, as defined in Title 28, California Code of Regulation (28 CCR) § 1300.67.2.2(b), within the Network Service Area.

7. Emergency Services: Emergency Services shall be available and accessible within the Network Service Area twenty-four (24) hours a day, seven (7) days a week.

8. Network Provider to Member Ratios: The ratio of Members to staff within a Network, including physicians and other health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all Covered Services will be accessible to Members on an appropriate basis without delays detrimental to Members' health.

    a. There shall be at least one full-time equivalent (FTE) physician to each one thousand two hundred (1,200) Members, and there shall be approximately one FTE primary care physician (PCP) for each two thousand (2,000) Members.

    b. For specialty types not specified in the Specialist Physician Ratio Standards and Methodology and the Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology documents, CalOptima Health shall ensure a ratio of Members to Providers within a Network such as to reasonably assure that all services will be accessible to Members on an appropriate basis without delays detrimental to Members' health.

9. Network Providers accepting new patients: CalOptima Health and its Health Networks shall ensure the numbers of Network Providers accepting new patients is sufficient to reasonably assure that all Covered Services will be accessible to all Members on an appropriate basis without delays detrimental to Members' health.

    a. CalOptima Health shall ensure timely access to care for all Members and shall meet the standards for Network Providers that are accepting new patients in compliance with Health and Safety Code (HSC) § 1367.035, including the standards for the percent of primary care physicians and non-physician mental health professionals accepting new patients.

10. Access to non-Network Providers: CalOptima Health shall arrange for the provision of Covered Services from non-Network Providers if the services are unavailable from a Network Provider, in accordance with 28 CCR § 1300.67.2.2(c), and 28 CCR § 1300.74.72, as applicable to

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Behavioral Health Care Services, when Medically Necessary for the Member's condition.

a. In such instances, CalOptima Health shall provide and arrange coverage from a non-Network Provider in a manner that meets the access requirements and Network Adequacy standards set forth in this policy.

11. Member Education: CalOptima Health's health education program shall include informing Members about access to Covered Services and the availability of referral to non-Network Providers if Network Providers are unavailable, as defined in 28 CCR § 1300.67.2.2(b).

B. Network Providers

1. CalOptima Health and its Health Networks shall maintain an adequate Network that includes all Provider types of the appropriate specialty and type necessary to deliver Covered Services.

2. CalOptima Health and its Health Networks shall provide readily available and accessible physicians, facilities, clinics, mental health Providers, and other non-physician medical Providers who are appropriately licensed, certified or eligible for certification by the applicable specialty boards, and serve as Network Providers, as defined in 28 CCR § 1300.67.2.2(b)(10).

3. When a hospital or other facility is a Network Provider, CalOptima Health shall make available individual Network Providers to deliver all Covered Services available at the facility, including emergency room care, through the following:

a. Facility-based Providers; and

b. Providers who maintain medical staff privileges, such as hospital admitting privileges, hospital care provision privileges, or emergency medicine privileges, at the facility pursuant to the hospital's credentialing policies and procedures and 28 CCR § 1300.51(d)(H).

4. Essential Community Providers

a. CalOptima Health shall provide reasonable and timely access to Covered Services for low-income and medically underserved populations in each geographic rating region where CalOptima Health provides services to Covered California Members by providing access to Essential Community Providers (ECPs). CalOptima Health shall comply with all laws, rules and regulations relating to arrangements with ECPs, as applicable, including those rules set forth in Title 45, Code of Federal Regulations § 156.235.

b. CalOptima Health and its Health Networks shall include at least fifteen percent (15%) of ECPs providing primary care services and at least fifteen percent (15%) of ECPs providing behavioral health services as defined in Section 4.3.4(d) of the CalOptima Health Contract with Covered California in its Network Service Area. If unable to meet this requirement, CalOptima Health and its Health Networks shall include at least fifteen percent (15%) of 340b non-hospital Providers and increase the Network each year to achieve the sufficiency requirement.

c. CalOptima Health shall contract with at least one (1) Provider in each of the following categories in the Network Service Area, where available:

i. Federally Qualified Health Centers;

ii. Ryan White Program Providers;

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iii. Family Planning Providers;

iv. Indian Health Care Providers;

v. Inpatient hospitals;

vi. Mental Health Facilities;

vii. Substance Use Disorder Treatment Centers; and

viii. Other ECP Providers, including Rural Health Clinics, black lung clinics, hemophilia treatment centers, sexually transmitted disease clinics, tuberculosis clinics, and rural emergency hospitals.

d. CalOptima Health shall notify Covered California with respect to any change to its ECP contracting arrangements, geographic distribution, percentage coverage, ECP classification type (e.g., 340B), and other information relating to ECPs within thirty (30) business days of any change in ECP contracts.

e. CalOptima Health shall notify Covered California of any pending change in its ECP contracting arrangements at least sixty (60) days prior to any change or immediately upon CalOptima Health's knowledge of the change if knowledge is acquired less than sixty (60) days prior to the change and shall cooperate with Covered California in planning for the orderly transfer of plan Members.

5. Indian Health Care Providers (IHCPs): CalOptima Health shall allow IHCPs to voluntarily enter into a contract at any time. If CalOptima Health is unable to contract with an IHCP, CalOptima Health shall allow eligible Members to obtain services from IHCPs. If CalOptima Health does not have any IHCPs in the Network, CalOptima Health shall allow eligible Members to obtain services from an out-of-Network IHCP.

6. If there is a shortage of Network Provider types in the Network Service Area, CalOptima Health and its Health Networks shall refer Members to available and accessible contracted Providers in neighboring service areas. If there are no contracted Providers outside the Network Service Area, CalOptima Health and its Health Networks shall refer Members to out-of-Network Providers in accordance with CalOptima Health Policies GG.1539: Authorization for Out-of-Network and Out-of-Area Services and EE.1141: CalOptima Health Provider Contracts.

C. Time or Distance Standards and Network Capacity Ratios

1. CalOptima Health and its Health Networks shall meet time or distance standards based on actual or projected enrollment, unless CalOptima Health has a DMHC-approved alternative time or distance standard.

2. Standards are established for both time or distance; however, in order to be compliant with the standards, CalOptima Health and its Health Networks must meet either time or distance, where applicable.

3. CalOptima Health and its Health Networks shall have a medical director, or licensed Physician acting on behalf of the medical director, available twenty-four (24) hours a day, seven (7) days a week to assist with access issues.

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4. Emergency Services: Emergency Services shall be available immediately to a Member twenty-four (24) hours a day, seven (7) days a week.

    a. CalOptima Health and its Health Networks shall cover Emergency Services without Prior Authorization.

    b. CalOptima Health shall have a designated Emergency Service facility within the Network Service Area, providing care twenty-four (24) hours a day, seven (7) days a week. This designated Emergency Service facility will have one (1) or more physicians and one (1) nurse on duty in the facility at all times.

    c. CalOptima Health and its Health Networks shall provide adequate follow-up care for those Members who have been screened in the emergency room in accordance with CalOptima Health Policy GG.1122: Follow-up for Emergency Department Care.

    d. CalOptima Health and its Health Networks shall ensure that a medical director or licensed physician is available twenty-four (24) hours a day, seven (7) days a week to authorize Medically Necessary post-stabilization care services, to respond to hospital inquiries within thirty (30) minutes, and to coordinate the transfer of stabilized Members in an emergency department, and for general communication with emergency room personnel, if necessary, in accordance with CalOptima Health Policy CC.1600: Authorization and Processing of Referrals.

5. Primary care Providers: All Members have a residence or workplace within thirty (30) minutes or fifteen (15) miles of a contracted primary care Provider in such numbers and distribution as to accord to all Members a ratio of at least one primary care Provider (on a FTE basis) to each 2,000 enrollees.

6. Hospitals: All Members have a residence or workplace within thirty (30) minutes or fifteen (15) miles of a contracted hospital which has a capacity to serve the entire dependent Member population based on normal utilization, and, if separate from such hospital, a contracting or plan-operated Provider of all emergency health care services.

7. Hospital Staff Privileges: There is a complete Network of contracting or plan-employed primary care physicians and specialists, each of whom has admitting staff privileges with at least one contracting or plan-operated hospital equipped to provide the range of Covered Services.

8. Ancillary Services: Ancillary laboratory, pharmacy and similar services and goods dispensed by order or prescription by the primary care Provider are available from contracting or plan-operated Providers at locations (where Members are personally served) within a reasonable distance from the primary care Provider.

9. Mental Health Professionals: All Members have a residence or workplace within fifteen (15 miles) of a mental health professional, unless an Alternative Access Standard (AAS) is approved, in such numbers and distribution as to accord to all Members a ratio of at least one mental health Provider (on a FTE basis) to each 1,000 enrollees or contracted with thirty percent (30%) of total licensed professionals in the service area.

10. Mental Health Facilities: All Members have a residence or workplace within fifteen (15) miles of a mental health facility unless an AAS is approved.

11. Specialist Physicians: All Members have a residence or workplace within fifteen (15) miles of the specialist physician types and within the ratio standards listed below:

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Specialist Physician Type	Distance Standard	Ratio Standard (Provider FTE: Member)
Cardiovascular Disease	15 miles	1:8000
Dermatology	15 miles	1:15,000
Gastroenterology	15 miles	1:15,000
Neurology	15 miles	1:8,000
Obstetrics/Gynecology	15 miles	1:5,500
Oncology	15 miles	1:15,000
Ophthalmology	15 miles	1:15,000
Podiatry	15 miles	1:15,000
Psychiatry	15 miles	1:5,500
Pulmonology	15 miles	1:15,000
Surgery-General	15 miles	1:5,500
Surgery-Orthopedic	15 miles	1:8,000
Allergy/Immunology	15 miles	1:32,000
Endocrinology	15 miles	1:22,000
Hematology	15 miles	1:22,000
Nephrology	15 miles	1:22,000
Otolaryngology	15 miles	1:22,000
Pain Medicine	15 miles	1:22,000
Physical Medicine and Rehabilitation	15 miles	1:22,000
Radiation Oncology	15 miles	1:32,000
Rheumatology	15 miles	1:32,000
Urology	15 miles	1:22,000

D. Timely Access

1. If it is necessary for a Provider or a Member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member's health care needs and ensures Continuity of Care consistent with good professional practice.

2. In addition to ensuring compliance with the clinical appropriateness standard, CalOptima Health shall ensure that its Network has adequate capacity and availability of licensed health care Providers to offer enrollees appointments that meet the following timeframes:

Description	Standard (timeframe from when the request for an appointment was made)
Urgent care appointments for services that DO NOT require Prior Authorization	Within 48 hours
Urgent care appointments for services that require Prior Authorization	Within 96 hours
Non-urgent appointments for primary care	Within 10 business days

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Description	Standard (timeframe from when the request for an appointment was made)
Non-urgent appointments with specialist physicians	Within 15 business days
Non-urgent appointments with a non-physician mental health care Provider or substance use disorder Provider	Within 10 business days
Nonurgent follow up appointments with a nonphysician mental health care or substance use disorder Provider	Within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition
Non-urgent appointments for Ancillary Services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days

3. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed Provider, or the health professional providing Triage or Screening Services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member.

4. Preventive Care services and periodic follow-up care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac, mental health, or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice, as determined by the treating Provider acting within the scope of their practice.

5. A referral to a specialist by a PCP or another specialist shall be subject to the relevant time-elapsed standard in the table above.

6. CalOptima Health and its Health Networks may demonstrate compliance with the primary care time-elapsed standards through standards, processes, and systems that provide Advanced Access to primary care appointments.

7. Dental care services: CalOptima Health or its Health Networks shall ensure that dental Networks have adequate capacity and availability of Providers to offer Members appointments for covered dental services in accordance with the following standards:

    a. Urgent appointments within the dental plan Network shall be offered within seventy-two (72) hours of the time of request for appointment, if consistent with a Member's individual needs and as required by professionally recognized standards of dental practice;

    b. Non-urgent appointments shall be offered within thirty-six (36) business days of the request for appointment; and

    c. Preventive dental care appointments shall be offered within forty (40) business days of the request for appointment.

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8. CalOptima Health and its Health Networks shall ensure that Members have effective and appropriate access to Covered Services in a timely manner, in accordance with the standards of this policy.

   a. If CalOptima Health or a Health Network has a shortage of one or more types of Providers in its Network Service Area, or a portion of its Network Service Area, CalOptima Health shall ensure timely access to Covered Services, including applicable time-elapsed standards, by referring Members to available and accessible Network Providers in neighboring Network Service Areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the Member's health needs.

   b. CalOptima Health or its Health Networks shall arrange for the provision of Covered Services from Providers outside the Network if unavailable within the Network, if Medically Necessary for the Member's condition. CalOptima Health shall ensure that Member costs for Medically Necessary referrals to non-Network Providers shall not exceed applicable in-Network co-payments, co-insurance, and deductibles. This does not prohibit CalOptima Health or its Health Networks from accommodating a Member's preference to wait for a later appointment from a specific Network Provider.

   c. If Medically Necessary treatment of a mental health or substance use disorder is not available in Network within the geographic and timely access standards set by law or regulation, CalOptima Health shall arrange coverage outside the Network in accordance with HSC § 1374.72(d).

9. Telephone Triage or Screening Services: CalOptima Health shall provide or arrange for the provision, twenty-four (24) hours a day, seven (7) days a week, of Triage or Screening Services by telephone.

   a. CalOptima Health shall ensure that telephone Triage or Screening Services are provided in a timely manner appropriate for the Member's condition, and that the Triage or Screening Waiting Time does not exceed thirty (30) minutes.

   b. CalOptima Health or a Health Network may provide telephone Triage or Screening Services through:

      i. CalOptima Health-operated telephone Triage or Screening Services;

      ii. Telephone medical advice services;

      iii. CalOptima Health's contracted primary care and mental health care or substance use disorder Network; or

      iv. Another method that provides Triage or Screening Services consistent with the requirements of this policy.

   c. If CalOptima Health arranges for the provision of telephone Triage or Screening Services through primary care, mental health care, and substance use disorder Network Providers, CalOptima Health shall require those Providers to maintain a procedure for triaging or screening Member telephone calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine, an answering service, or office staff, that shall inform the caller of both of the following:

      i. Regarding the length of wait for a return call from the Provider; and

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ii. ow the caller may obtain urgent care or Emergency Services, including, when applicable, how to contact another Provider who has agreed to be on-call to triage or screen by telephone, or if needed, to deliver urgent care or Emergency Services.

d. If CalOptima Health arranges for the provision of Triage or Screening Services through Network primary care, mental health care, and substance use disorder Providers who are unable to meet the time-elapsed standards in this policy, CalOptima Health shall also provide or arrange for the provision of contracted or CalOptima Health-operated Triage or Screening Services, which shall, at a minimum, be made available to Members affected by that portion of the CalOptima Health Network.

e. An unlicensed staff person handling Member calls may ask questions on behalf of a licensed staff person in order to help ascertain the condition of a Member so that the Member may be referred to a licensed staff person. However, an unlicensed staff person shall not, under any circumstances, use the answers to those questions to assess, evaluate, advise, or make any decision regarding the condition of a Member or determine when a Member needs to be seen by a licensed medical professional.

f. CalOptima Health shall ensure that the availability of Triage and Screening Services, and how to obtain those services, is included in the Evidence of Coverage and shall disclose the standards for timely access.

g. CalOptima Health shall include the telephone number for accessing Triage and Screening Services on Member ID cards or through a menu option in the customer service telephone answering system.

h. CalOptima Health and its Health Networks shall ensure that, during normal business hours, the waiting time for a Member to speak by telephone with a CalOptima Health or Health Network customer service representative who is knowledgeable and competent regarding the Member's questions and concerns does not exceed ten (10) minutes.

i. Emergency message during business hours: All Members shall be referred to the nearest emergency room. CalOptima Health and a Health Network shall have in its recorded message to include the following: "If you feel that this is an emergency, hang up and dial nine-one-one (911) or go to the nearest emergency room."

10. Telephone access after business hours:

a. After-hours access: A PCP or their Designee, who shall be an appropriately licensed professional under the physician's supervision, shall be available twenty-four (24) hours a day, seven (7) days a week, to respond to after-hours Member calls or to a hospital emergency room Provider.

b. If a live after-hours attendant answers and the call is an emergency, the attendant shall refer the Member to nine-one-one (911) Emergency Services or instruct the Member to go to the nearest emergency room.

c. If a recorded message answers, it shall include the following: "If you feel that this is an emergency, hang up and dial nine-one-one (911) or go to the nearest emergency room."

11. Cultural and Linguistic (C&L) Services:

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a. C&L Services shall be provided in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

b. Interpreter Services: CalOptima Health or its Health Networks shall coordinate interpreter services with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment without imposing delay on the scheduling of the appointment.

III. PROCEDURE

A. Network Monitoring

1. CalOptima Health and its Health Networks shall continually monitor the Network, evaluate Member access to care, and promptly address issues that impact CalOptima Health's ability to deliver care to Members in accordance with access requirements and Network Adequacy standards, including accessibility, availability, Continuity of Care, Network capacity, and timely access requirements.

2. When identifying Network accessibility problems, CalOptima Health shall consider Member Grievances, the unavailability of Network Providers, shortages of one or more Provider types within the Network, requests for referrals to non-Network Providers, delays in access to care, and other indicators of lack of Member access to Covered Services.

B. When reviewing Network issues, CalOptima Health shall document any conclusions regarding compliance with Network Adequacy and timely access requirements.

C. Participating Provider Stability: CalOptima Health will assess, on an ongoing basis, turnover rates of its participating Providers to ensure that the turnover rates do not disrupt the delivery of quality care in accordance with CalOptima Health's Contract with Covered California, Section 4.3.2(b).

D. CalOptima Health shall annually conduct the following as a means to collect Network Adequacy data for monitoring CalOptima Health's Provider Network and Health Networks, in accordance with a valid and reliable survey methodology and designed to ascertain compliance with the standards set forth in 28 CCR § 1300.67.2.2(c):

1. Tracking and documenting Network capacity and availability with respect to the standards set forth in this policy, including:

a. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys and/or other Member experience surveys such as Annual Provider Survey;

b. Behavioral Health Member Experience Survey; and

c. Geographic Access Mapping.

2. Member Experience Survey, which will:

a. Obtain Members' perspectives and concerns regarding their experience obtaining health care services within the standards set forth in this policy;

b. Inform Members of their right to obtain an appointment within each of the time-elapsed standards set forth in this policy, and their right to receive interpreter services at that appointment. This notice shall be in addition to the notice requirements set forth in HSC §

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1367.031. The notice may be included in the survey or in a document attached to the survey.

c. Evaluate the experience of limited English proficient Members in obtaining interpreter services by obtaining the Members' perspectives and concerns regarding:

i. Coordination of appointments with an interpreter;

ii. Availability of interpreters who speak the Member's preferred language; and

iii. Quality of interpreter services received.

d. Be translated into the Member's preferred language, in those situations where:

i. CalOptima Health is aware of the Member's preferred language; and

ii. The Member's preferred language is one of the top fifteen (15) languages spoken by limited English proficient individuals in California as determined by the Department of Health Care Services.

3. Provider Satisfaction Survey of physicians and non-physician mental health Provider perspectives and concerns regarding compliance with the standards set forth in this policy. In addition, the Provider Satisfaction Survey shall evaluate Provider perspectives and concerns with CalOptima Health or its Health Network's language assistance program regarding:

a. Coordination of appointments with an interpreter;

b. Availability of an interpreter, based on the needs of the Member; and

c. The ability of the interpreter to effectively communicate with the Provider on behalf of the Member.

4. Timely Access Survey: CalOptima Health and its Health Networks shall achieve a 70% urgent care rate of compliance, a 70% non-urgent care rate of compliance, and an 80% non-physician mental health Provider follow-up rate of compliance. If not, CalOptima Health will investigate, submit a Corrective Action Plan (CAP), and may be subject to disciplinary action by the DMHC.

5. Provider Appointment Availability Survey, in accordance with the requirements in the Provider Appointment Availability Survey Manual and the Timely Access Submission Instruction Manual.

E. Network Monitoring

1. CalOptima Health's Access and Availability Workgroup along with other business areas shall annually monitor a Member's ability to access care by reviewing data that includes but is not limited to the following:

a. Timely access and appointment availability;

b. Members' and Providers' experience as it relates to access;

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c. Behavioral health reports on access and availability of contracted Behavioral Health Care Providers;

d. Telephone access, including telephone answer and return call wait time, and triage and screening services; and

e. In-office wait time.

2. The Access and Availability Workgroup along with other business areas shall quarterly monitor a Member's ability to access care by reviewing data that includes but is not limited to the following:

a. Grievances and Appeals data;

b. Network Adequacy (FTE Provider/Member ratio, Network Provider types, and time/distance) data;

c. Encounter/claims data;

d. Potential quality issues; and

e. Telephone wait times through reports from the call center.

3. Access and availability performance against the standards set forth in this policy shall be reported to the Member Experience Sub-Committee by the Access and Availability Workgroup Chair, or Designee, on a quarterly basis to:

a. Analyze and report results in order to:

i. Prioritize opportunities for improvement identified from analyses.

ii. Implement interventions on at least one (1) area of opportunity (if applicable) for the following areas:

a) Non-Behavioral Health Care services; and

b) Behavioral Health Care services.

iii. Evaluate the effectiveness of interventions for improving access to non-behavioral and Behavioral Health Care services.

4. CalOptima Health shall annually develop the following:

a. Accessibility analysis (appointment availability and access during and after business hours) report; and

b. Availability analysis (Provider/Member ratio and distance/time) report.

5. At least once every three years, CalOptima Health shall confirm that the Advanced Access programs reported by Network Providers and Provider Groups are scheduling appointments as in compliance with the definition of Advanced Access in this policy.

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6. CalOptima Health and its Health Networks shall require Network Providers to give written notice no later than thirty (30) calendar days immediately following the date upon which a Network Provider no longer provides Advanced Access appointments to Members.

7. CalOptima Health shall also review the available information related to access and availability for Providers offering Advanced Access appointments, including Member Grievances and Appeals.

F. Out of Network access: CalOptima Health shall authorize and arrange for out-of-Network access in the following circumstances:

1. CalOptima Health does not have an AAS (as defined below) approved by the DMHC and fails to meet the timely access or Network Adequacy standards set forth in 28 CCR § 1300.67.2.

2. CalOptima Health shall identify Providers not complying with timely access standards and shall:

a. Communicate to the Provider when they are not compliant with timely access standards;

b. Track and escalate corrective action for Providers with continued non-compliance;

c. For Providers with two (2) consecutive instances of non-compliance, send a warning; and

d. For Providers with three (3) consecutive instances of non-compliance, refer the Provider to the Member Experience Sub-Committee for review and further action in consideration of Member access to appropriate services.

G. Request for Alternative Access Standards (AAS):

1. CalOptima Health shall submit an AAS request to DMHC when:

a. Unable to demonstrate compliance with meeting time or distance standards and not utilizing Telehealth to meet compliance with time or distance standards; or

b. A significant change in the Network occurs and CalOptima Health no longer meets time or distance standards.

2. Such requests will be made in accordance with 28 CCR § 1300.67.2.1 and alternative time-elapsed standards or threshold rates for compliance, 28 CCR § 1300.67.2.2(f), as applicable.

3. A request for an alternative time-elapsed standard or an alternative to time-elapsed standards shall include:

a. An explanation of CalOptima Health's clinical and operational reasons for requesting the alternative standard, together with information and documentation, including scientifically valid evidence (based on reliable and verifiable data), demonstrating that the proposed alternative standard is consistent with professionally recognized standards of practice and a description of the expected impact of the alternative standard on clinical outcomes, access for Members, and Network Providers;

b. Information demonstrating and substantiating why a proposed alternative standard is more appropriate than the standards set forth in this policy;

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c. A description of all the steps CalOptima Health has taken, and any additional steps CalOptima Health will take to demonstrate its reasonable efforts, to bring its Network into compliance with the existing standards set forth under 28 CCR § 1300.67.2.2, including contracting with additional Providers. The description shall include how the request for the alternative standard will address any changes or deficiencies noted by CalOptima Health between the results of the current and prior year's Provider Appointment Availability Surveys; and

d. If an AAS is granted, CalOptima Health shall file, on an annual basis, an amendment with DMHC requesting approval for continued use of the alternative standard and providing updated information and documentation to substantiate the continued need for the alternative standard.

H. Network Disruptions

1. If CalOptima Health experiences any Network hospital with a pending contract termination, including any hospitals that may experience a break in maintaining a continuous contract, CalOptima Health shall provide prior notice to Covered California as specified in Section III.H.3 below.

2. If CalOptima Health experiences any other Provider Network disruptions or other similar circumstances that make it necessary for at least ten percent (10%) of Members residing within any county of an affected region to change participating Providers, as detailed in the Qualified Health Plan Network Disruption Reporting Template, CalOptima Health will provide prior notice to Covered California as specified in Section III.H.3 below and in accordance with advance notice, meeting, and other requirements set forth in applicable laws, rules, and regulations, including HSC §§ 1367.23 and 1366.1.

3. As required by Section 4.3.3(c)(1) of CalOptima Health's Contract with Covered California, CalOptima Health shall notify Covered California with respect to changes in the Provider Network as follows:

a. Any pending change in the composition of the Provider Network at least sixty (60) days prior to any change or immediately upon CalOptima Health's knowledge of the change if knowledge is acquired less than sixty (60) days prior to the change, and cooperate with Covered California in planning for the orderly transfer of plan Members; and

b. CalOptima Health shall ensure that Covered California Members have access to care when there are changes in the Network, including mid-year contract terminations.

4. Member transfers

a. In the event of a change in participating Providers or qualified health plans related to Network disruption, Block Transfers, or other similar circumstances, CalOptima Health shall, and shall require participating Providers to, cooperate with Covered California in planning for the orderly transfer of Members as necessary and as required under applicable laws, rules and regulations, including those relating to Continuity of Care.

b. In the event of a Block Transfer, CalOptima Health shall notify Members and the DMHC in accordance with CalOptima Health Policy CC.1300: Block Transfers.

I. Reporting

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1. ECPs: Upon request, CalOptima Health shall provide a Provider data file to Covered California for the purpose of determining compliance with the ECP standard.

2. CalOptima Health shall file annually with the DMHC:

    a. Timely Access Compliance Report in accordance with 28 CCR § 1300.67.2.2.(h)(6), including CalOptima Health's Provider Appointment Availability Survey Report Forms and any non-compliance information and descriptions of corrective actions;

    b. Annual Network Report in accordance with 28 CCR § 1300.67.2.2.(h)(7); and

    c. Accompanying Network Access Profile information.

    d. CalOptima Health shall designate an individual as a compliance officer who shall be responsible for reviewing and submitting the required reports and information and verifying that the information and data submitted within the reports and the Network access profile is true and correct and does not contain misstatements or omissions of material fact.

3. To demonstrate compliance with time or distance standards, CalOptima Health shall cover 100% of the population points in the zip code for Members with any deficiencies accounted for through AAS requests.

    a. CalOptima Health and its Health Networks shall not require Members to access services via Telehealth in place of in-person services.

    b. CalOptima Health may use third-party corporate Telehealth Providers if a Member chooses to use Telehealth in accordance with HSC § 1374.141.

J. CalOptima Health shall provide the Member Experience Sub-Committee and the Health Networks with access and availability results of CalOptima Health and Health Networks' performance, including results from DMHC compliance reviews. These results shall include CalOptima Health's assessment results against the access and availability standards as set forth in this policy.

1. If the Member Experience Sub-committee identifies access-related deficiencies or non-compliance of standards or requirements set forth in this policy, the Chair of the Member Experience Sub-Committee, or Designee, may take the following steps:

    a. Request that a Health Network submit a Quality Improvement Plan (QIP) or Plan-Do-Study-Act (PDSA) cycle(s) for performance measures that are deemed deficient or non-compliant, if applicable;

    b. Submit a Request for Compliance Action to the Office of Compliance to request corrective action, if applicable. Such corrective action may include the issuance of a request for a CAP and/or the imposition of Sanctions, in accordance with CalOptima Health Policies HH.2005: Corrective Action Plan and HH.2002: Sanctions, respectively; and

    c. Report the deficiencies or non-compliance to the Audit and Oversight Committee and/or Compliance Committee, as appropriate.

K. CalOptima Health shall ensure that Health Networks comply with Network Adequacy and access requirements as set forth in this policy.

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1. Members who receive care through Health Networks shall have the same access to required Providers as they would through the CalOptima Health Provider Network.

2. CalOptima Health has contractual provisions and policies and procedures in place for identifying when changes in a Provider Network, Health Network, and downstream Provider Network results in CalOptima Health being out of compliance with any standards set forth in this policy.

3. If a Health Network has been identified as having a deficient Network component(s) and/or fails to meet Network Adequacy components:

   a. CalOptima Health and the Health Network shall authorize services through out-of-Network Providers to ensure members receive timely and appropriate care.

   b. The Health Network shall submit a QIP or PDSA, if requested.

   c. The Health Network shall submit a CAP to the CalOptima Health Office of Compliance, if necessary. A Health Network shall take all necessary and appropriate action to identify the causes underlying the access-related deficiencies, including but not limited to a review of whether Provider hours of operation and/or Providers' scheduling practices contributed to the deficiencies, and resolve such deficiencies, to comply with the standards of this policy and CalOptima Health Policy HH.2005: Corrective Action Plan.

4. The Quality Analytics Department shall coordinate performance reviews to assess adherence to access and availability standards, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

5. The Quality Analytics Department shall annually update CalOptima Health's Access and Availability desktop procedures to assess adherence to access and availability standards, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Age Discrimination Act of 1975
B. California Civil Code, §51
C. California Government Code, §11135
D. CalOptima Health Authorization Required List
E. CalOptima Health Contract for Health Care Services
F. CalOptima Health Contract with Covered California
G. CalOptima Health Operational Audit Tool
H. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
I. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
J. CalOptima Health Policy GG.1122: Follow-up for Emergency Department Care
K. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
L. CalOptima Health Policy GG.1619: Delegation Oversight
M. CalOptima Health Policy HH.2002: Sanctions
N. CalOptima Health Policy HH.2005: Corrective Action Plan
O. CalOptima Health Quality Assurance Plan

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P. DMHC All Plan Letter (APL) 24-021: Notice of Amendments to Rules 1300.67.2.1, 1300.67.2 and Incorporated Documents – Network Adequacy Standards and Methodology for RY 2025
Q. DMHC APL 22-030: Requirement for Plans to "Arrange for" Covered Services
R. DMHC APL 24-019: Amendments to Rule 1300.67.2.2 and the Incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for RY 2025
S. HSC §§ 1367.03(a)(1) and (7), 1367.2, 1375.9(a)
T. 28 CCR §§ 1300.51(d)(H)(I); 1300.67.2(d) and (f); 1300.67.2.1(a); 1300.67.2.2(d)(2) and (3); 1300.70(a)(1) and (3); 1300.51 (d)(I)(4) and (6); 1300.67.2; 1300.67.2.2 (3) and (c)(7)(C);
U. Title 28, Code of Federal Regulations, Part 36
V. Title 29, United States Code (USC), §794 (Section 504 of the Rehabilitation Act of 1973)
W. Title 42, United States Code (USC), §2000d
X. Title 45, Code of Federal Regulations, Part 80, Part 84, and Part 91
Y. Title VI of the Civil Rights Act of 1964
Z. Title IX of the Education Amendments of 1973
AA. National Committee of Quality Assurance (NCQA) standards

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1700	Standards of Accessibility and Timely Access	Covered California

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IX. GLOSSARY

Term	Definition
Advanced Access	The provision, by a Network Provider, or by the Provider Group to which a Member is assigned, of appointments with a primary care physician, or other qualified primary care Provider, such as a Nurse Practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the Member prefers not to accept the appointment offered within the same or next business day.
Alternative Access Standard (AAS)	An alternative to the existing access standard approved by DMHC when a managed care plan has exhausted all other reasonable options for obtaining Providers in order to meet the applicable standards, or if DMHC determines that the requesting managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.
Ancillary Services	Covered Services that are not physician or hospital services, including lab work or diagnostic testing, such as mammogram or MRI, or treatment such as physical therapy.
Appeal	A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR § 438.408(b).
Behavioral Health Care	Treatment and services provided to treat mental health and substance use disorder conditions.
Block Transfer	A transfer or redirection of two thousand (2,000) or more Members by CalOptima Health or a Health Network from a terminated Provider Group or terminated hospital to one or more contracting Providers that takes place as a result of the termination or non-renewal of a Provider contract.
Continuity of Care	Services provided to a Member rendered by an out-of-Network Provider with whom the Member has a pre-existing Provider relationship.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Covered California, Department of Managed Health Care (DMHC), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators in accordance with HH.2005: Corrective Action Plan.
Covered Services	Health care services that are covered benefits under CalOptima Health's contract with Covered California as further described in the Evidence of Coverage and supporting documents.

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Term	Definition
Cultural and Linguistic (C&L) Services	Services that promote equal access to health care services and are responsive to a Member's cultural and linguistic needs. These services include but are not limited to: 1. Recruiting bilingual employees for appropriate positions whenever possible, and enhancing employees' bilingual skills and cultural sensitivity through employee development programs; 2. Providing twenty-four (24)-hour access to interpreter services at key points of contact for all Members; 3. Providing translations of informational materials in threshold languages, providing oral translation for other languages upon request or as needed, and providing information and materials to meet the needs of Members with sensory impairments; and 4. Referring Members to culturally and linguistically appropriate community services, as needed.
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.
Emergency Services	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 § 438.114 and H&S § 1317.1(a)(1).
Grievance	Any expression of dissatisfaction about any matter other than an adverse benefit determination, and may include, but is not limited to the quality of care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health 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 CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.
Health Network	A physician hospital consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a health maintenance organization (HMO), subcontractor, or first tier entity, that contracts with CalOptima Health to provide Covered Services to members.

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Term	Definition
Medically Necessary or Medical Necessity	Health care and related services and supplies provided to a Member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care Provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results. For treatment of a mental health or substance use disorder, Medical Necessity shall include: A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) in accordance with the generally accepted standards of mental health and substance use disorder care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; (iii) not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care Provider, as required by HSC §1374.72 (a)(3)(A).
Member	An individual enrolled in CalOptima Health's Covered California health plan.
Network	A discrete set of Network Providers CalOptima Health has designated to deliver all Covered Services for a specific Network Service Area.
Network Adequacy	Having sufficient Provider Network in all of the following components: FTE Provider/Member ratio, Network Provider types, and time/distance.
Network Service Area	The geographical area, and population points contained therein, where CalOptima Health is approved by the DMHC to arrange health care services consistent with Network Adequacy requirements. "Population points" means a representation of where people live and work in the state of California based on United States Census Bureau population data and United States Postal Service delivery route data, and made available annually by the DMHC on the web portal accessible at www.dmhc.ca.gov. Network Service Area includes the Covered California region(s) that CalOptima Health is approved to operate in under the terms of the DMHC license and Covered California contract.
Nurse Practitioner	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards as specified in Title 16 California Code of Regulations § 1484.
Preventive Care	Health care provided for prevention and early detection of disease, illness, injury, or other health conditions and, in the case of a full-service plan includes all of the following health care services required by HSC §§ 1345(b)(5), 1367.002, 1367.3 and 1367.35 and 28 CCR § 1300.67(f).
Prior Authorization	A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services.

For 20250605 BOD Review Only

Term	Definition
Provider Group	A group of physicians or other health care professionals that is clinically integrated, financially integrated, or that contract together to provide care to patients in a coordinated manner.
Rural Health Clinic	An entity defined in Title 22, California Code of Regulations § 51115.5
Sanctions	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a first tier, downstream, or related entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health programs according to CalOptima Health Policy HH.2002: Sanctions.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Members's health care while the Member is at the originating site, and the Provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.
Triage or Screening Services	The assessment of a Member's health concerns and symptoms via telephone or other means of communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to perform screen or triage a Member who may need care, for the purpose of determining the urgency of the Member's need for care.
Triage or Screening Waiting Time	The time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to provide Triage or Screening Services to a Member who may need care.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contact

Donna Laverdiere, Executive Director, Strategic Development, (714) 986-6981

Recommended Actions

Approve New CalOptima Health Policy CC.2000: Emergency Declaration, effective January 1, 2027.

Background

On August 1, 2024, the CalOptima Health Board of Directors (Board) authorized the Chief Executive Officer (CEO) to convene a stakeholder steering committee composed of key external partners and providers to discuss considerations for potential participation in Covered California. CalOptima Health leadership and staff convened the Covered California Stakeholder Steering Committee, which has met on nine separate occasions. On October 3, 2024, the Board directed the CEO to request the Orange County Board of Supervisors (BOS) to amend CalOptima Health's governing ordinance to remove the prohibition on participation in Covered California. On January 14, 2025, the BOS unanimously voted to amend the ordinance to allow CalOptima Health's participation in Covered California. On December 5, 2024, the Board approved actions related to Covered California consulting support contracts and associated funding.

CalOptima Health must obtain approval to operate a Covered California product under its Knox-Keene Act license from the California Department of Managed Health Care (DMHC). Obtaining a Knox-Keene Act license or expanding an existing license is a regulatory filing process that all plans must comply with to offer an individual market health plan. While CalOptima Health is currently licensed with DMHC for the OneCare Medicare product, CalOptima Health must submit a filing to expand its current Knox-Keene Act license to participate in the individual market. As a first step in this process, CalOptima Health participated in a pre-filing conference with DMHC on February 25, 2025.

Discussion

The DMHC filing process is a multi-phased process that CalOptima Health must complete by early 2026 to obtain the proper approvals to operate an individual market health plan. The process requires the submission of at least 89 supporting exhibits that demonstrate compliance with the requirements of the Knox-Keene Act.

Several of the documents that must be submitted to DMHC are policies and procedures that demonstrate compliance with statutory and regulatory requirements. Staff has evaluated the policies and procedures that are needed to demonstrate compliance. Staff recommends approval of a new policy and procedure to demonstrate compliance with Knox-Keene Act emergency declaration requirements.

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Policies & Procedures Summary – Emergency Declaration

The DMHC license filing requires submission of a policy detailing procedures for when a state of emergency or health emergency is declared. To demonstrate compliance with these requirements, staff proposes new Policy CC.2000: Emergency Declaration.

This new policy is developed to demonstrate compliance with DMHC requirements regarding:

- Submitting a DMHC filing within 48 hours of a State of Emergency declared by the Governor or a Health Emergency declared by the State Public Health Officer;
- Reporting to DMHC how many members are affected, if any;
- Reporting to DMHC on steps CalOptima Health is taking to ensure access to care for affected members; and
- Compliance with any subsequent DMHC guidance issued during the emergency.

To meet the health emergencies requirements, staff drafted Policy CC.2000: Emergency Declaration to establish requirements for DMHC filings when a State of Emergency has been declared. The policy also specifies the procedures for additional requirements, if applicable, to ensure access to care for CalOptima Health members during the State of Emergency.

This new policy demonstrates compliance with the following statutory requirements and DMHC guidance:

- California Health & Safety Code § 1368.7; and
- DMHC All Plan Letter 23-002: Health Emergencies Guidance.

Staff seeks Board approval of the attached new policy, effective January 1, 2027.

Fiscal Impact
The recommended action is operational in nature and has no anticipated fiscal impact.

Rationale for Recommendation
Approval of CalOptima Health Policy CC.2000: Emergency Declaration will support CalOptima Health's application to expand its Knox-Keene Act license to operate an individual market plan.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Attachment 1: CalOptima Health Policy CC.2000: Emergency Declaration

/s/ Michael Hunn *05/29/2025*
Authorized Signature **Date**

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Policy:	CC.2000
Title:	**Emergency Declaration**
Department:	Strategic Development
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2027
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☒ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250605 BOD Review Only

I. PURPOSE

The purpose of this policy is to outline CalOptima Health's process to comply with Health & Safety Code § 1368.7 and Department of Managed Health Care (DMHC) All Plan Letter (APL) 23-002: Senate Bill 979 – Health Emergencies Guidance, as well as any amendments or successor guidance to those materials.

II. POLICY

A. CalOptima Health shall regularly monitor for any State of Emergency or Health Emergency Declaration (Declaration) by the Governor or the State Public Health Officer, respectively.

B. CalOptima Health shall, within forty-eight (48) hours of a Declaration, file with the DMHC a notification in accordance with this policy.

C. CalOptima Health shall comply with any other regulatory guidance pursuant to Health & Safety Code § 1368.7 during the first three (3) years following the declaration of emergency, or until the emergency is terminated, whichever occurs first.

III. PROCEDURE

A. CalOptima Health will regularly monitor for any Declaration by the Governor or the State Public Health Officer, respectively.

B. Within forty-eight (48) hours of a Declaration in Orange County, CalOptima Health will submit a filing to the DMHC that outlines the following:

1. Whether the Declaration may displace or otherwise affect CalOptima Health's contracted Providers or Members.

2. Whether CalOptima Health has experienced or expects to experience any disruption to its operations.

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3. How CalOptima Health is communicating with potentially impacted Members.

4. The actions CalOptima Health is taking to ensure that the health care needs of Members are met.

C. CalOptima Health will comply with the DMHC's requirements related to the Declaration, which may include:

1. Shortening time limits for authorization or referrals or extending the time that authorizations or referrals remain valid.

2. Extending the filing deadlines for Provider claims.

3. Suspending prescription refill limitations and allowing an impacted Member to refill their prescriptions at an out-of-network pharmacy.

4. Authorizing a Member to replace medical equipment or supplies.

5. Allowing a Member to access appropriate out-of-network counseling services if contracted Providers are unavailable due to the emergency or the Member is out of the area due to displacement.

6. Maintaining a toll-free telephone number that an affected Member may call for answers to questions, including questions about the loss of health insurance identification cards, access to prescription refills, or how to access health care.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with Covered California
B. California Health and Safety Code § 1368.7
C. Department of Managed Health Care (DMHC) All Plan Letter (APL) 23-002: Senate Bill 979 – Health Emergencies Guidance

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.2000	State of Emergency	Covered California

For 20250605 BOD Review Only

IX. GLOSSARY

Term	Definition
Health Emergency	A declaration by the State Public Health Officer pursuant to Government Code § 101080
Member	An individual enrolled in a CalOptima Health program.
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services.
State of Emergency	A declaration by the Governor pursuant to Government Code § 8625

For 20250605 BOD Review Only

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contacts

Michaell Rose, Chief Health Equity Officer, (657) 235-6757
Marie Jeannis, RN, MSN, CCM, Executive Director, Population Health Management, (714) 246-8591

Recommended Actions

Approve new CalOptima Health Policy GG.1705: Community Reinvestment, in accordance with regulatory requirements, effective June 1, 2025.

Background

As part of the Comprehensive Quality Strategy and Population Health Management (PHM) Policy Guide, the Department of Health Care Services (DHCS) is requiring Medi-Cal Managed Care Plans (MCPs) to implement a Community Reinvestment Program.

The Community Reinvestment Program supports DHCS' broader health equity goals by requiring MCPs, like CalOptima Health, to reinvest a portion of their net income into community-driven solutions that address social drivers of health and reduce health disparities. Community reinvestments must align with upstream, evidence-informed priorities that promote long-term health improvements for Medi-Cal members. Community reinvestment dollars are not intended to fund activities included in the MCP contract with DHCS or services covered under Medi-Cal.

Discussion

CalOptima Health establishes new policies and procedures to implement federal and state laws and regulations, contracts, and business practices. Additionally, CalOptima Health staff performs annual policy reviews to add or update internal procedures to ensure compliance with applicable requirements.

In February 2025, DHCS released All Plan Letter (APL) 25-004: Community Reinvestment Requirements with guidance for the implementation of the Community Reinvestment Program. The purpose of Policy GG.1705: Community Reinvestment is to define CalOptima Health's Community Reinvestment Program requirements and describes the process by which CalOptima Health will invest in local communities.

Staff will return to the Board of Directors with additional details on recommended community reinvestment activities.

Fiscal Impact

Staff will evaluate financial performance and ensure compliance with the community reinvestment requirements pursuant to the DHCS Primary Agreement. The fiscal impact will be reflected in CalOptima Health's financial statements.

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Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, staff recommend that the CalOptima Health Board of Directors approve and adopt new CalOptima Health Policy GG.1705: Community Reinvestment.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Policy GG.1705 Community Reinvestment

/s/ Michael Hunn *05/30/2025*
Authorized Signature **Date**

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Policy:	GG.1705
Title:	**Community Reinvestment**
Department:	Equity and Community Health
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	06/01/2025
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☐ Covered California ☒ Medi-Cal ☐ OneCare ☐ PACE

For 20250608 BOD Review Only

I. PURPOSE

This policy defines CalOptima Health's community reinvestment program requirements and describes the process by which CalOptima Health and qualifying Subcontractors will invest in local communities.

II. POLICY

A. CalOptima Health shall establish and maintain a community reinvestment program in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 25-004: Community Reinvestment Requirements.

B. CalOptima Health shall ensure community reinvestments are focused toward reducing existing health disparities and/or promoting health outcomes for Members through investments primarily focused on upstream causes of poor health such as:

1. Housing instability;
2. Food insecurity;
3. Poverty;
4. Barriers in access to health and social services; and
5. Environments that negatively impact health.

C. CalOptima Health shall align community reinvestment activities with the following principles, in accordance with DHCS APL 25-004: Community Reinvestment Requirements:

1. Engage with the community;
2. Align community identified priorities with investments in health outcomes and equity; and
3. Ensure funding targets non-contract activities.

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D. CalOptima Health will ensure community reinvestment activities align with DHCS permitted categories.

E. Community reinvestment activities will be directly informed by the Orange County Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) processes led by the Orange County Health Care Agency (OCHCA) with meaningful participation by CalOptima Health, in accordance with CalOptima Health Policy GG.1667: CalAIM Population Health Management Program and the DHCS Behavioral Health Transformation (BHT) process.

F. Community reinvestment funds will not be allocated towards activities included in the DHCS Contract with CalOptima Health or services carved out of that contract but covered under Medi-Cal.

G. Community reinvestment obligations will not be met through expenditures for:

1. Provision of health care services to eligible Members within scope of Medi-Cal benefits or state-funded services as defined in the primary or secondary operations contracts with DHCS, inclusive of all exhibits and attachments;

2. Provision of health care services to eligible Members within the scope of Medi-Cal benefits or state-funded services that are carved out of the primary or secondary operations contracts;

3. Health care services inclusive of activities that improve health care quality, as defined in Title 42 Code of Federal Regulations (CFR) section 438.8(e)(3);

4. CalOptima Health administrative activities;

5. Procedural or administrative activities related to community reinvestment planning or implementation; or

6. Member incentives or Member Grants.

H. CalOptima Health and qualifying Subcontractors will engage the Chief Health Equity Officer in the community reinvestment planning process and ensure all community reinvestment plans align with overall Health Equity needs and priorities.

I. CalOptima Health's planning and decision-making process for activities based on net income for calendar year (CY) 2025 and thereafter will include Local Health Jurisdictions (LHJ) and County Behavioral Health.

J. CalOptima Health and qualifying Subcontractors will initiate investments in community reinvestment activities no later than the close of the CY in which DHCS approves the initial Community Reinvestment Plan for the applicable investment period, and the community reinvestment funding obligations for each three (3) year investment period will be spent on specific activities included in the initial Community Reinvestment Plan by the end of the three (3) year period.

K. CalOptima Health shall submit a Community Reinvestment Plan starting in early Quarter Three (Q3) of CY 2026 and annually thereafter, unless CalOptima Health and qualifying Subcontractors do not have positive net income for the applicable CY.

III. PROCEDURE

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A. CalOptima Health reinvestment program planning will begin in CY 2025 with subsequent community reinvestment activities starting in CY 2026.

B. Community Reinvestment Activity Categories

1. CalOptima Health shall make investments in activities that fall within the following five (5) permitted use categories in accordance with DHCS APL 25-004: Community Reinvestment Requirements. Activities may correspond to one (1) or more categories:

a. Cultivating Neighborhoods and Built Environment – investments that create neighborhoods and environments that promote health, well-being, and safety.

b. Cultivating a Health Care Workforce – investments in health workforce development, recruitment, and training for diverse providers.

c. Cultivating Well-Being for Priority Populations – investments that address community-specific needs through tailored supports and services not covered under CalOptima Health contract with DHCS for Medi-Cal Services.

d. Cultivating Local Communities – investments that bolster the lives of individuals and contribute to the advancement and wellbeing of a community.

e. Cultivating Improved Health – investments targeted toward upstream root causes of poor health that address immediate and long-term health related needs as defined by the community.

C. Community Engagement

1. CalOptima Health shall engage and consult stakeholders, Member Advisory Committee (MAC) to:

a. Solicit community reinvestment recommendations.

b. Validate the Community Reinvestment Plan ensuring investments are adequately focused on the needs of the community.

2. CalOptima Health will collaborate with the LHJ OCHCA and County Behavioral Health for community reinvestment planning and decision-making.

3. CalOptima Health shall coordinate with other Medi-Cal Managed Care Plans (MCP) operating in Orange County to engage with LHJs during the community reinvestment planning process.

D. Community Reinvestment Allocation

1. There are two types of community reinvestment obligations: Base Community Reinvestment and Quality Achievement Community Reinvestment (QACR).

a. Base Community Reinvestment

i. CalOptima Health will collaborate with its Accounting Department to establish Base Community Reinvestment allocations.

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ii. Base Community Reinvestment is the minimum level of net income CalOptima Health is required to invest in initiatives that serve the local communities, starting with net income based on CY 2024 contract revenues for community reinvestment activities initiated in CY 2026.

iii. CalOptima Health shall allocate Base Community Reinvestment funds equal to:

a) Five percent (5%) of CalOptima Health's annual net income that is less than or equal to seven and a half percent (7.5%) of Medi-Cal Contract Revenues for the year; and

b) Seven and a half percent (7.5%) of CalOptima Health's annual net income that is greater than seven and a half percent (7.5%) of Medi-Cal Contract Revenues for the year.

iv. Qualifying Subcontractors shall allocate Base Community Reinvestment funds equal to:

a) Five percent (5%) of the qualifying Subcontractor's annual net income that is less than or equal to seven and a half percent (7.5%) of revenues under its agreement with CalOptima Health.

b) seven and a half percent (7.5%) of the qualifying Subcontractor's annual net income that is greater than seven and a half percent (7.5%) of revenues under its agreement with CalOptima Health.

c) Subcontractors are permitted but not required to transfer Base Community Reinvestment obligations to CalOptima Health to administer funds on their behalf.

b. Quality Achievement Community Reinvestment (QACR)

i. Quality Achievement Community Reinvestment (QACR) is the net income CalOptima Health will invest in initiatives where CalOptima Health operates and does not meet the minimum quality measure performance thresholds for the applicable CY, beginning with CY 2024.

ii. CalOptima Health will collaborate with organizational Quality Improvement Department to establish QACR allocations.

iii. For any contract year where CalOptima Health receives an Enforcement Tier 2 or Tier 3 assignment in accordance with DHCS APL 23-012: Enforcement Actions: Administrative and Monetary Sanctions:

a) CalOptima Health will reinvest at a minimum an additional seven and a half percent (7.5%) of annual net income into community reinvestment initiatives

b) CalOptima Health will allocate 100% of the QACR funds toward investments in the Cultivating Improved Health category as described in Section III.B. of this policy.

iv. QACR funds are separate and distinct from performance withholds or monetary sanctions imposed due to not meeting required quality performance levels.

c. Net Positive Income

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i. In contract years where CalOptima Health and qualifying Subcontractors generate net positive income, CalOptima Health and qualifying Subcontractors must allocate funds for Base Community Reinvestment and/or QACR as required by Section III.D. of this policy.

ii. If CalOptima Health does not generate positive net income within a calendar year, qualifying Subcontractors are still subject to Base Community Reinvestment requirements if Subcontractors has positive net income.

d. On an annual basis beginning in CY 2026, DHCS will calculate CalOptima Health minimum community reinvestment funding obligations according to DHCS APL 25-004: Community Reinvestment Requirements.

i. CalOptima Health will notify qualifying Subcontractors of any minimum community reinvestment funding obligations and any corrections to obligations within seven (7) calendar days of notice from DHCS.

E. Community Reinvestment Plan

1. The Community Reinvestment Plan describes the permitted community reinvestment activities for each three (3) year investment period beginning with CY 2026 and recurring every three (3) years after.

2. CalOptima Health shall develop an initial Community Reinvestment Plan that includes:

a. A detailed description of the anticipated Community Reinvestment activities and their related use category or categories

b. A description of how activities are directly informed by community needs identified through the LHJ CHA process

c. If applicable, identification of the LHJ CHIP activity that each community reinvestment activity matches

d. If applicable, a description of community needs identified through the BHT community planning process that the community reinvestment activity addresses

e. Anticipated benefits of community reinvestment activities in alignment with criteria described DHCS APL 25-004: Community Reinvestment Requirements.

f. A description of the approach taken to engage the MAC in the community reinvestment planning process, including a summary of the recommendations.

g. A description of the approach taken to engage other interested stakeholders in the community reinvestment planning process, if any, and identification of those stakeholders

h. A description of any investments recommended by MAC not included in the Community Reinvestment Plan.

i. A summary of input provided by the Chief Health Equity Officer, and the Quality Improvement Health Equity Committee (QIHEC) if applicable.

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j. The expected dollar amount allocated for each community reinvestment activity, based on the overall funding obligation for the applicable CY.

k. The expected populations that will benefit from or participate in each community reinvestment activity.

l. A description of how the impact of community reinvestment activities will be measured and evaluated.

m. A signed attestation from local Public Health and County Behavioral Health Directors.

3. Each subsequent Community Reinvestment Plan within the investment period will either:

a. Indicate the allocation of additional investments for each activity documented in the initial Community Reinvestment Plan for funding obligations resulting from positive net income for the applicable CY; and/or

b. Propose funding allocations for any new/revised activities for the applicable CY that meet all requirements in accordance with DHCS APL 24-005: Community Reinvestment Requirements.

4. Each subsequent Community Reinvestment Plan within the three (3) year investment period will include at a minimum:

a. The expected dollar amount allocated for each community reinvestment activity in the initial Community Reinvestment Plan approved by DHCS based on funding obligations resulting from positive net income for the applicable CY.

b. A signed attestation from local Public Health and County Behavioral Health Directors.

5. Beginning in CY 2026 and on an annual basis, CalOptima Health will submit the initial or subsequent Community Reinvestment Plans, unless net income is negative for the applicable CY, using templates in accordance with DHCS APL 25-004: Community Reinvestment Requirements Appendix B.

6. CalOptima Health will submit the Community Reinvestment Plans to the Board of Directors and DHCS for review and approval.

7. CalOptima Health will post the Community Reinvestment Plan within thirty (30) days of DHCS approval on CalOptima Health's public facing website.

F. Community Reinvestment Implementation

1. CalOptima Health will:

a. Begin community reinvestment activities no later than the close of the CY in which DHCS approves the Community Reinvestment Plan.

b. Expend all funds for the initial investment period by the close of CY 2029.

c. Spend community reinvestment funds on activities in DHCS approved Community Reinvestment Plan, in accordance with CalOptima Health Policy AA.1400: CalOptima Health Grants Management Policy.

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G. Community Reinvestment Report

1. CalOptima Health shall:

a. Publish a Community Reinvestment Report every three (3) years, beginning in Quarter Two (Q2) CY 2030, that includes:

i. The actual dollar amount spent on each community reinvestment activity by county;

ii. Description of each community reinvestment activity by category and county;

iii. Description of how each community reinvestment activity aligns with DHCS' Guiding Principles described in DHCS APL 25-004: Community Reinvestment Requirements;

iv. Description of how each community reinvestment activity aligns with designated reinvestment categories; and

v. Outcomes from community reinvestment activities, including any preliminary data and qualitative description of benefits to Members and the communities in which they reside.

b. Post the Community Reinvestment Report on CalOptima Health's public facing website, using templates included in DHCS APL 25-004: Community Reinvestment Requirements, Appendix D.

c. Submit a Community Reinvestment Report to DHCS.

i. Submission will include signed letters from the MAC, and at minimum, the letters will describe the degree to which CalOptima Health engaged the stakeholder in community reinvestment planning efforts and include their feedback regarding the completed reinvestment activities.

IV. ATTACHMENT(S)

A. Appendix B: Community Reinvestment Plan Template
B. Appendix B, Exhibit 1: Attestation of Support from Public Health Director
C. Appendix B, Exhibit 2: Attestation of Support from County Behavioral Health Director
D. Appendix D: Community Reinvestment Report

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy AA.1400 CalOptima Health Grants Management Policy
C. CalOptima Health Policy GG.1667: CalAIM Population Health Management Program
D. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Program Guide (Supersedes APLs 17-012 and 17-013)
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-012: Enforcement Actions: Administrative and Monetary Sanctions (Supersedes APL 22-015)(Revised 12/04/2023)
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-021: Population Needs Assessment and Population Health Management Strategy (Supersedes APL 19-011)
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 25-004: Community Reinvestment Requirements

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H. Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide, May 2024
I. California Welfare and Institutions Code (WIC), §5963.03, subdivision (a)(1)
J. Title 42 Code of Federal Regulations (CFR) §438.8(e)(3)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2025	GG.1705	Community Reinvestment	Medi-Cal

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IX. GLOSSARY

Term	Definition
Base Community Reinvestment	The minimum level of net income that an managed care plan (MCP) with positive net income is required to invest into initiatives that serve the communities in which the MCP operates, starting with net income based on calendar year (CY) 2024 Contract Revenues for Community Reinvestment activities initiated in CY 2026.
Behavioral Health Transformation	Department of Health Care Services (DHCS) implementation of ballot initiative Proposition 1 to modernize the behavioral health delivery system to improve accountability, increase transparency, and expand the capacity of behavioral health care facilities.
Community Health Assessment (CHA)	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)	The output of the Community Health Assessment (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 Reinvestment Plan	A document outlining the reinvestment activities in local communities.
Department of Health Care Services (DHCS)	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
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.
Health Equity	The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
Medi-Cal Managed Care Plan (MCP)	A health plan contracted with the Department of Health Care Services (DHCS) that provides Covered Services to Medi-Cal beneficiaries.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
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.

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Term	Definition
Quality Achievement Community Reinvestment	The additional net income that CalOptima is required to invest into initiatives in counties where CalOptima Health operates in which they do not meet minimum quality measure performance thresholds for the applicable CY, starting with CY 2024. CalOptima Health's Contract with the Department of Health Care Services (DHCS) requires CalOptima Health to allocate Quality Achievement Community Reinvestment funds equal to 7.5% of its annual net income.
Quality Improvement Health Equity Committee (QIHEC)	A committee facilitated by CalOptima Health'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.
Subcontractor(s)	An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

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Overview & Instructions

Each Community Reinvestment Plan will cover a three-year investment period in alignment with the timelines for LHJ CHA / CHIP and BHT Integrated Plan as described in Section VII of the APL.

The **initial Community Reinvestment Plan** for each investment period must include: (i) the proposed Community Reinvestment activities for the MCP and its Qualifying Subcontractors for the duration of the investment period; and (ii) the intended allocation of investments across each proposed activity for funding obligations resulting from positive net income in the applicable CY.

Each **subsequent Community Reinvestment Plan** within the investment period must indicate the allocation of additional investments for each activity documented in the initial Community Reinvestment Plan for funding obligations resulting from positive net income for the applicable CY.

For reference, the timeline for Community Reinvestment Plan submissions for the first two (2) investment periods is included below.

Investment Period		Due:	Allocations Based on:
1	Initial Community Reinvestment Plan	Early Q3 CY 2026	CY 2024 net income
	Subsequent Community Reinvestment Plan	Early Q3 CY 2027	CY 2025 net income
	Subsequent Community Reinvestment Plan	Early Q3 CY 2028	CY 2026 net income
2	Initial Community Reinvestment Plan	Early Q3 CY 2029	CY 2027 net income
	Subsequent Community Reinvestment Plan	Early Q3 CY 2030	CY 2028 net income
	Subsequent Community Reinvestment Plan	Early Q3 CY 2031	CY 2029 net income

MCPs must submit a Community Reinvestment Plan to DHCS using the templates provided within this Appendix and pursuant to specific timelines and process to be communicated by DHCS subsequent to this APL release. Within 30 days of DHCS approval, MCPs are required to post the approved Community Reinvestment Plan on their website.

In order for the Community Reinvestment Plan submission to be considered complete, each MCP must submit the following documents as part of their Community Reinvestment Plan**:**

- **Exhibit 1: Signed Attestation of Support** from the local Public Health Director **for each local health jurisdiction in which the MCP operates**.

- **Exhibit 2: Signed Attestation of Support** from the County Behavioral Health Director **for each county in which the MCP operates**.

- **Exhibit 3: Signed Attestation of Acknowledgment (for CY 2024 Community Reinvestment only)** from local Public Health and County Behavioral Health Directors for current, voluntary investments claimed toward CY 2024 Community Reinvestment obligations **for each county in which the MCP operates**. This attestation only applies to the Community Reinvestment Plan due in early Q3 CY 2026, and only if the MCP is claiming current, voluntary investments to fulfill part or all of its Community Reinvestment obligation.

- **Exhibit 4: Summary of Proposed Community Reinvestment Activities.** MCPs with positive net income for the applicable CY **must complete and submit this form for each proposed Community Reinvestment activity** at minimum for the first year in each investment period. If an MCP and its Qualifying Subcontractors intend to modify its investment activities in years two and/or three of the investment period, it must complete and submit this form for the applicable CY.

- **Exhibit 5: Allocation of Community Reinvestment Obligations Across Counties.** MCPs with positive net income for the applicable CY must indicate the proposed allocation of Community Reinvestment funds **for each county in which it operates**, including any investments by its Qualifying Subcontractors. MCPs must complete and submit this form on an annual basis for each year of the investment period based on net income for the applicable CY.

[MCP LETTERHEAD]
APPENDIX B, EXHIBIT 1: ATTESTATION OF SUPPORT FROM PUBLIC HEALTH DIRECTOR

Subject: Attestation of Support for Community Reinvestment Plan

I, the undersigned, as an officer of (county / city Name), hereby attest that (MCP name's) Community Reinvestment Plan for investments anticipated in (calendar year / calendar years):

- Aligns with community needs identified in the most current CHA / CHIP:
  ☐ Yes ☐ No (If no, please briefly describe the rationale below):

- Includes an investment strategy that is aligned with the CHA/CHIP:
  ☐ Yes ☐ No (If no, please briefly describe below)

- Includes an investment strategy that is agreeable to the LHJ:
  ☐ Yes ☐ No (If no, please briefly describe the rationale below):

- Includes proposed investment activities that are agreeable to the LHJ:
  ☐ Yes ☐ No (If no, please briefly describe the rationale below)

By:

_____
(Please type full name here)

_____
(Please type title here)

_____
(Signature)

_____
(Date)

[MCP LETTERHEAD]
APPENDIX B, EXHIBIT 2: ATTESTATION OF SUPPORT FROM COUNTY BEHAVIORAL HEALTH DIRECTOR

Subject: Attestation of Support for Community Reinvestment Plan

I, the undersigned, as an officer of (county name), hereby attest that (MCP name's) Community Reinvestment Plan for investments anticipated in (calendar year / calendar years):

- Aligns with community needs identified in the most current CHA / CHIP:
  ☐ Yes ☐ No (If no, please briefly describe the rationale below):

- Is informed by needs identified in the Behavioral Health Transformation planning process:
  ☐ Yes ☐ No (If no, please briefly describe the rationale below):

- To the extent CHA/CHIP includes behavioral health needs as identified by the community, the County Behavioral Health Department agrees that the investment strategy is aligned with the CHA/CHIP:
  ☐ Yes ☐ No (If no, please briefly describe below):

- Includes proposed investment activities that are agreeable to the County Behavioral Health Department:
  ☐ Yes ☐ No (If no, please briefly describe the rationale below):

By:

_____
(Please type full name here)

_____
(Please type title here)

_____
(Signature)

_____
(Date)

[MCP LETTERHEAD]
APPENDIX B, EXHIBIT 3: ATTESTATION OF ACKNOWLEDGMENT

Subject: Attestation of Acknowledgement of Community Reinvestment Plan

Local Public Health Director

I, the undersigned, as an officer of (county / city name), hereby attest that (MCP name) has informed the LHJ of its Community Reinvestment Plan and proposed investment activities based on CY 2024 net income:

By:

_____
(Please type full name here)

_____
(Please type title here)

_____
(Signature)

_____
(Date)

County Behavioral Health Director

I, the undersigned, as an officer of (county name), hereby attest that (MCP name) has informed the County Behavioral Health Department of its Community Reinvestment Plan and proposed investment activities based on CY 2024 net income:

By:

_____
(Please type full name here)

_____
(Please type title here)

_____
(Signature)

_____
(Date)

[MCP LETTERHEAD]
APPENDIX B, EXHIBIT 4: PROPOSED COMMUNITY REINVESTMENT ACTIVITIES

Instructions: Please transcribe this document onto your MCP's letterhead in the header without changing any wording below. MCPs must provide the information requested by DHCS below separately for each proposed Community Reinvestment activity for the applicable investment period.

If an MCP's Qualifying Subcontractor intends to invest in an activity separate and distinct from any of the MCP's proposed activities, the MCP must submit a separate Exhibit 4 form for the Qualifying Subcontractor. However, the MCP does not need to submit a separate form for the Qualifying Subcontractor if the MCP's Qualifying Subcontractor intends to invest in the same activity as the MCP.

Description of Proposed Community Reinvestment Activities	
Question	**Response**
1) Provide a detailed description of the Community Reinvestment and the related use category or categories for the activity.	
2) Please indicate all counties of operation where investments for this activity will occur.	
3) Please specify the intended timeline for funding this activity (e.g., the CY 2026 – CY 2029 investment period based on CY 2024 – CY 2026 net income).	
4) Provide a description of how the activity is informed by the LHJ's CHA. Please include a link or hard copy of the most recent CHA.	
5) If applicable, provide a description of how the activity is informed by the BHT community planning process.	

[MCP LETTERHEAD]
APPENDIX B, EXHIBIT 4: PROPOSED COMMUNITY REINVESTMENT ACTIVITIES

Description of Proposed Community Reinvestment Activities	
Question	**Response**
6) If applicable, identify the LHJ CHIP activity that the Community Reinvestment activity matches. Please include a link or hard copy of the most recent CHIP.	
7) Provide a description of the anticipated benefits of the Community Reinvestment activity, populations expected to benefit, and alignment with guiding principles identified in the APL. Note: If this activity is intended to meet the MCP's Quality Achievement Community Reinvestment requirement, the MCP must indicate how the activity aligns with the "Cultivating Improved Health" category.	
8) Provide a description of the approach taken to engage the CAC in the Community Reinvestment planning process, including a summary of input and recommendations provided.	
9) If applicable, provide a description of the approach taken to engage other community stakeholders in the Community Reinvestment planning process, including a summary of stakeholders involved and any input or recommendations provided.	
10) Provide a description of any investments recommended by the CAC not included in the Community Reinvestment Plan.	

[MCP LETTERHEAD]
APPENDIX B, EXHIBIT 4: PROPOSED COMMUNITY REINVESTMENT ACTIVITIES

Description of Proposed Community Reinvestment Activities	
Question	**Response**
11) Provide a summary of input provided by the Chief Health Equity Officer on the Community Reinvestment Plan and/or planning efforts.	
12) If applicable, provide a summary of input provided by the QIHEC on the Community Reinvestment Plan and/or planning efforts.	
13) Provide a description of how the Community Reinvestment activity will be measured and evaluated.	
14) If applicable, please provide the name of any Qualifying Subcontractors that intend to invest in this activity.	

[MCP LETTERHEAD]
APPENDIX B, EXHIBIT 5: PROPOSED ALLOCATION OF FUNDS

Instructions: Please transcribe this document onto your MCP's letterhead in the header without changing any wording below. Please fill out the information for all proposed Community Reinvestment activities for the applicable county. MCPs with positive net income for the applicable CY must complete this form for all counties in which it operates.

County Name:

Proposed Allocation of Funds by the MCP

Brief Description of Activity	Allocation of Base or Quality Achievement Funds?	Funding Allocation for Investment Period		
		Y1	Y2	Y3
Ex) Investment in community garden	Base Community Reinvestment	$400,000	$200,000	$-
Total	-			

Proposed Allocation of Funds by Qualifying Subcontractor(s)

Subcontractor Name	Brief Description of Activity	Funding Allocation for Investment Period		
		Y1	Y2	Y3
	Ex) Investment in community garden	$400,000	$200,000	$-
Total	-			

[MCP LETTERHEAD]
APPENDIX B, EXHIBIT 1: ATTESTATION OF SUPPORT FROM PUBLIC HEALTH DIRECTOR

Subject: Attestation of Support for Community Reinvestment Plan

I, the undersigned, as an officer of (county / city Name), hereby attest that (MCP name's) Community Reinvestment Plan for investments anticipated in (calendar year / calendar years):

- Aligns with community needs identified in the most current CHA / CHIP:
  ☐ Yes ☐ No (If no, please briefly describe the rationale below):

- Includes an investment strategy that is aligned with the CHA/CHIP:
  ☐ Yes ☐ No (If no, please briefly describe below)

- Includes an investment strategy that is agreeable to the LHJ:
  ☐ Yes ☐ No (If no, please briefly describe the rationale below):

- Includes proposed investment activities that are agreeable to the LHJ:
  ☐ Yes ☐ No (If no, please briefly describe the rationale below)

By:

_____
(Please type full name here)

_____
(Please type title here)

_____
(Signature)

_____
(Date)

[MCP LETTERHEAD]
APPENDIX B, EXHIBIT 2: ATTESTATION OF SUPPORT FROM COUNTY BEHAVIORAL HEALTH DIRECTOR

Subject: Attestation of Support for Community Reinvestment Plan

I, the undersigned, as an officer of (county name), hereby attest that (MCP name's) Community Reinvestment Plan for investments anticipated in (calendar year / calendar years):

- Aligns with community needs identified in the most current CHA / CHIP:
  ☐ Yes ☐ No (If no, please briefly describe the rationale below):

- Is informed by needs identified in the Behavioral Health Transformation planning process:
  ☐ Yes ☐ No (If no, please briefly describe the rationale below):

- To the extent CHA/CHIP includes behavioral health needs as identified by the community, the County Behavioral Health Department agrees that the investment strategy is aligned with the CHA/CHIP:
  ☐ Yes ☐ No (If no, please briefly describe below):

- Includes proposed investment activities that are agreeable to the County Behavioral Health Department:
  ☐ Yes ☐ No (If no, please briefly describe the rationale below):

By:

_____
(Please type full name here)

_____
(Please type title here)

_____
(Signature)

_____
(Date)

[MCP LETTERHEAD]
APPENDIX D, COMMUNITY REINVESTMENT REPORT

Overview & Instructions

Each Community Reinvestment Plan will extend over a three-year investment period in alignment with the timelines for LHJ CHA / CHIP and BHT Integrated Plan as described in Section VII of the APL.

MCPs must post a Community Reinvestment Report on their website and provide the link to DHCS **in Q2 CY 2030, and every three years thereafter, using the templates provided within this Appendix**. Please transcribe the Community Reinvestment Report Template onto your MCP's letterhead in the header without changing any wording. The Community Reinvestment Report must detail the composite set of Community Reinvestment activities conducted in each county of operation, listed separately for MCPs and their Qualifying Subcontractors

The MCP's submission of the Community Reinvestment Report website link to DHCS must also include a hard copy of the signed letter from the CAC that at minimum describes the degree to which the MCP engaged the CAC in Community Reinvestment planning efforts and the CAC's feedback regarding the completed Community Reinvestment activities.

[MCP LETTERHEAD]
APPENDIX D, COMMUNITY REINVESTMENT REPORT

MCP Community Reinvestment Activities in (County Name) for CY (Year) through CY (Year)

Description of Activity	Dollar Amount Invested	Alignment with State Defined Use Categories	Base or Quality Achievement Allocation?
Ex) Investment in community garden	$600,000	Cultivating Neighborhoods and Built Environment	Base Community Reinvestment

Alignment of Community Reinvestment Activities with Guiding Principles
Ex) Investments informed by community members and limited access to healthy food as identified in CHA

Outcomes from Community Reinvestment Activities
Ex) Access to affordable produce for community members with nearest grocery store >10 miles away

[MCP LETTERHEAD]
APPENDIX D, COMMUNITY REINVESTMENT REPORT

(Subcontractor Name) Community Reinvestment Activities in (County Name) for CY (Year) through CY (Year)

Description of Activity	***Dollar Amount Invested***	***Alignment with State Defined Use Categories***	***Base or Quality Achievement Allocation?***
Ex) Investment in community garden	$600,000	Cultivating Neighborhoods and Built Environment	Base Community Reinvestment

Alignment of Community Reinvestment Activities with Guiding Principles
Ex) Investments informed by community members and limited access to healthy food as identified in CHA

Outcomes from Community Reinvestment Activities
Ex) Access to affordable produce for community members with nearest grocery store >10 miles away

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

17. Authorize a License Agreement with the County of Orange for Use of Space at the County Community Service Center

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Deanne Thompson, Executive Director, Marketing and Communications, (657) 550-4736s

Recommended Actions

1. Authorize 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.
2. Approve allocation of up to $135,500 from existing reserves to fund the License Agreement, a full-time bilingual Spanish speaking Customer Service Representative, and general administrative costs for the period of July 1, 2025, through June 30, 2026.

Background

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

The County of Orange Social Services Agency (SSA) opened a County Community Service Center in Brea (CCSC Brea) on June 10, 2024. CCSC Brea is located at 675 Placentia Avenue, Suite 100, Brea, California, 92821 and operates Monday through Friday from 8 a.m. to 5 p.m. CCSC Brea is a one-stop shop for Orange County residents where their needs will be assessed to best match them to services and resources available from SSA, its co-located partners, and other government agencies and community-based organizations.

CCSC Brea offers a variety of health and human services to local residents, including resources and referrals, application assistance, education workshops, mental health programs, and other support services. Individuals can apply for benefit programs that provide support for groceries, no- or low-cost health insurance, and cash aid. The Orange County (OC) Health Care Agency's Behavioral and Mental Health connects individuals with mental health and substance use services and job seekers. Businesses can visit OC Workforce Solutions to access employment resources. The Office of Immigrant and Refugee Affairs also connects clients to services and resources for which they may be eligible. Community resource specialists can assist clients with vital records, such as birth and marriage certificates, DMV appointments to get ID cards or driver's licenses, and navigation of City and County services. Referrals to housing, childcare, and educational services will also be offered.

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Under the License Agreement, CalOptima Health will have a satellite office at CCSC Brea to provide member support services, offer health education workshops, and share information on the Medi-Cal program, services and support services. CalOptima Health will have a bilingual Spanish speaking Customer Service Representative to support members with the following:

- Answer member questions about programs;
- Assist with filing grievances and appeals;
- Assist with changing their primary care provider for CalOptima Health Community Network;
- Assist with changing their health network; and
- Assist with coordination of and access to services.

Currently, there are approximately 7,600 CalOptima Health members residing in the City of Brea and approximately 340,000 members living within a 10-mile radius of CCSC Brea. Brea is ranked 24 out of 34 when listing the incorporated cities where the most CalOptima Health members reside.

To create awareness of CalOptima Health's satellite office in the community, CalOptima Health will implement outreach strategies to inform members, internal departments, health networks, providers, and community-based organizations of the Brea CCSC and of the services available to the local community. Activities include communications to health networks and providers through CalOptima Health's newsletters and weekly communications and targeted site visits to providers, health clinics, and community-based organizations within a two-mile radius of CCSC Brea.

Discussion

Staff recommends Board-authorization to negotiate and execute a License Agreement to establish CalOptima Health's satellite office at CCSC Brea to provide information and services to members regarding their benefits and health education to support member health care needs. Staff will negotiate a License Agreement compliant with CalOptima Health's obligations under applicable state and federal laws regarding the privacy of CalOptima Health members and their protected health information.

The proposed License Agreement allows for one designated parking space and one dedicated office totaling 113 square feet within the CCSC Brea facility. The proposed license fee for the first year of the License Agreement is $2,950 per month. Thereafter, the monthly license fee will increase annually by 4% for each additional year. CalOptima Health will negotiate additional amendments, as necessary, to ensure compliance with applicable state and federal privacy requirements.

Description	**Fiscal Year 2025-26 Estimated Costs**
License Fee (12 months) • Fee includes leased space, IT services, telephone services, janitorial services, and electrical/utilities	$35,400
Full time bilingual Spanish speaking Customer Service Representative	$85,000
General administrative costs (including insurance, computer and telecommunications costs)	$15,100
Total	**$135,500**

Back to Agenda

As proposed, the License Agreement would take effect on July 1, 2025, contingent on successful negotiations with the County of Orange and the agreement being fully executed and approved by the OC Board of Supervisors. The County of Orange's proposed License Agreement is for a term of no more than ten years from July 1, 2025, through June 30, 2035. The License Agreement allows CalOptima Health to cancel the agreement at any time, with a 30-day written notice. Staff recommends the Board approve the License Agreement for the full ten-year period.

Fiscal Impact

The recommended action to establish a satellite office at the CCSC Brea is unbudgeted. An allocation of up to $135,500 from existing reserves will fund the expenses through June 30, 2026. Staff will include administrative expenses related to the satellite office in future operating budgets.

Rationale for Recommendation

As part of CalOptima Health's mission, staff work toward providing access to health care services for CalOptima Health members. By operating a satellite office in north Orange County, CalOptima Health is able to expand outreach to its members and build a presence in the community. In addition, the satellite office will provide CalOptima Health with an opportunity to provide direct support to members and increasing their ability to access health care.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. CalOptima Health License Agreement
3. CCSC Brea Flier

/s/ Michael Hunn *05/29/2025*
Authorized Signature **Date**

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Attachment 1 to June 5, 2025 Board of Directors Meeting – Agenda Item 17

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

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

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CEO/RFLC
CalOptima at Brea CCSC
675 Placentia Avenue, Suite 100 and 125
Brea, CA 92821

LICENSE AGREEMENT

THIS LICENSE AGREEMENT ("**License**") is made and entered into_____2025, ("**Effective Date**"), by and between ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA HEALTH, a public agency (hereinafter referred to as "**Licensee**") and the COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as "**County**" or "**Licensor**"), without regard to number and gender. County and Licensee may sometimes hereinafter be referred to individually as "**Party**" or jointly as "**Parties**."

RECITALS

I. County leases that certain real property located at 675 Placentia Avenue in the city of Brea, ("**County Property**") pursuant to a lease dated November 8, 2022, for use as the Community Customer Service Center ("**CCSC**").

II. Licensee would like to provide health related services, workshops and information regarding Medi-Cal benefits ("**Community Services**") at the County Property which will include a convenient on-site source while County clients are at the CCSC.

III. County agrees to provide Licensee office space within the CCSC for Licensee to provide the Services as further defined within this License.

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

1. DEFINITIONS (SRLic-1.0 S)

The following words in this License shall have the significance attached to them in this Clause 1 (DEFINITIONS), unless otherwise apparent from context:

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

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

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

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

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

2. LICENSE AREA (SRLic-1.1 S)

County grants to Licensee the right to exclusive use of one (1) office space, approximately one hundred thirteen (113) rentable square feet ("**RSF**") in that certain County Property located at 675 Placentia Avenue, Brea, California 92821, as described in Exhibit A and as shown on Exhibit B, which exhibits are attached hereto and by reference made a part hereof (hereinafter referred to as the "**License Area**"), together with non-exclusive right of common use of elevators, stairways, washrooms, hallways, driveways for vehicle ingress and egress, pedestrian walkways, parking, other facilities and common areas appurtenant to the License Area ("**Common Areas**"). This right also includes reasonable and non-exclusive right to access the License Area.

3. USE (SRLic-1.2 S)

Licensee's use of the License Area shall be limited to administrative and general office purposes, including providing clients with Community Services.

Licensee agrees not to use the License Area for any other purpose nor to engage in or permit any other activity within or from the License Area. Licensee further agrees not to conduct or permit to be conducted any public or private nuisance in, on, or from the License Area, not to commit or permit to be committed waste on the License Area, and to comply with all governmental laws and regulations in connection with its use of the License Area.

NO ALCOHOL, TOBACCO, OR MARIJUANA PRODUCTS SHALL BE SOLD FROM OR CONSUMED WITHIN THE LICENSE AREA. DRINKING ALCOHOLIC BEVERAGES AND SMOKING OF ANY KIND IS PROHIBITED INSIDE ANY BUILDING WITHIN THE LICENSE AREA.

4. COUNTY'S USE RESERVATIONS AND RIGHT OF ENTRY (1.3 S)

County reserves the right from time to time, without unreasonable interference, to access the License Area to confirm that Licensee is using the License Area consistent with those uses articulated in Clause 3 (USE). Licensee shall cooperate with County during County's access of the License Area. County shall notify Licensee at least forty-eight (48) hours in advance prior to accessing the License Area. Licensee and County shall work together in good faith to schedule the time of access to ensure it does not unreasonably interfere with Licensee's use of the License Area.

5. PARKING (SRLic-1.4 S)

County shall provide one (1) parking space for Licensee's free and non-exclusive use. The location and any rules or instructions for use of these parking space(s) shall be determined by the County.

6. TERMINATION OF PRIOR AGREEMENTS (SRLic-1.5 N) – *intentionally omitted*

7. TERM (SRLic-1.6 N)

This License shall commence on the Effective Date, first written above, and shall continue in effect for no more than ten (10) years ("**Term**") or as otherwise terminated in accordance with Clause 8 (TERMINATION) of this License.

8. TERMINATION (SRLic-1.7 N)

This License shall be revocable by either County or Licensee with thirty (30) days' written notice to the nonterminating Party prior to the termination date.

9. LICENSE FEE (SRLic-1.8 N)

Licensee agrees to pay County the sum of Two Thousand Nine Hundred Fifty Dollars and 00/100 ($2,950.00) per month as a fee for the use of the License Area ("**License Fee**"), commencing on the Effective Date and adjusted annually pursuant to the License Fee Schedule below. Said License Fee shall be payable in advance, without prior notice or demand, on the first day of each calendar month while this License is in effect, without deduction or offset, in lawful money of the United States.

In the event the obligation to pay the License Fee begins or terminates on some day other than the first day or last day of the month, the License Fee shall be prorated to reflect the actual period of use on the basis of a thirty (30) day month.

License Fee Schedule:

Period/Months	Monthly License Fee
1-12	$2,950
13-24	$3,068
25-36	$3,191
37-48	$3,318
49-60	$3,451
61-72	$3,589
73-84	$3,733
85-96	$3,882
97-108	$4,037
109-120	$4,199

10. PAYMENT PROCEDURE (SRLic-1.9 N)

All payments shall be delivered to:

County of Orange
County Administration North
CEO Fiscal Services/ CEO Real Estate

400 W. Civic Center Dr., 5th Floor
Santa Ana, CA 92701
Attn: Chief Real Estate Officer / Leasing

The designated place of payment may be changed at any time by County upon ten (10) days' prior written notice to Licensee. Payments may be made by check payable to the County of Orange. License Fee payment shall include a payment voucher indicating that the payment is for the monthly License Fee for office space at the SSA/Brea County Community Service Center in Brea, California. Licensee assumes all risk of loss if payments are made by mail.

No payment by Licensee or receipt by County of a lesser amount than the payment due under this License shall be deemed to be other than on account of the payment due, nor shall any endorsement or statement on any check or any letter accompanying any check or payment as payment be deemed an accord and satisfaction; County shall accept such check or payment without prejudice to County's right to recover the balance of said payment or pursue any other remedy in this License. Nor shall County's acceptance of a lesser amount due or delay in pursuing full payment act as a legal bar against County's recovery of any amount due under this License.

11. CHARGE FOR LATE PAYMENT (SRLic-2.0 N)

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

Accordingly, if any payment pursuant to this License is not received by County by the due date, a late charge of one - and one- half percent (1.5%) of the payment due and unpaid plus one hundred dollars ($100.00) shall be added to the payment, and the total sum shall become immediately due and payable to County. An additional charge of one- and one-half percent (1.5%) of said payment, excluding late charges, shall be added for each additional month that said payment remains unpaid.

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

Acceptance of such late charges (and/or any portion of the overdue payment) by County shall in no event constitute a waiver of Licensee's default with respect to such overdue payment, nor act as a legal bar or otherwise prevent County from exercising any of the other rights and remedies granted hereunder.

12. LICENSE ADMINISTRATIVE COST (SRLic-2.1 N) – *intentionally omitted*

13. MAINTENANCE OBLIGATIONS OF LICENSEE - CONDITIONS AND CARE OF LICENSE AREA (SRLic-2.2 S) – *Intentionally Omitted*

14. UTILITIES AND JANITORIAL (SRLic-2.3 N) – *Intentionally Omitted*

15. CONSTRUCTION AND/OR ALTERATION BY LICENSEE (SRLic-2.4 N)

County's Consent. No structures or facilities shall be constructed, erected, altered, or made within the License

Area without prior written consent of County. Licensee may make improvements and changes in the License Area, including, but not limited to, the installation of furniture, fixtures, partitions, shelving, counters, equipment and personal property as deemed necessary or appropriate to conduct its use, which consent will not be unreasonably withheld. Any conditions relating to the manner, method, design, and construction of said structures, improvements, or facilities fixed by the County as a condition to granting such consent, shall be conditions hereof as though originally stated herein.

Strict Compliance with Plans and Specifications. All improvements constructed by Licensee within the License Area shall be constructed in strict compliance with detailed plans and specifications approved by County and, to the extent applicable, in compliance with the requirements of California Public Contract Code Section 22000 *et seq*., and Labor Code Sections 1720 *et seq*. and 1770 *et seq*., which require those improvements to be constructed as if such improvements had been constructed under the direction and supervision, or under the authority, of County.

16. OWNERSHIP OF IMPROVEMENTS (SRLic-2.5 N)

All improvements, exclusive of trade fixtures, constructed, or placed within the License Area by Licensee ("**Licensee Improvements**") must, upon completion, be free and clear of all liens, claims, or liability for labor or material and, at County's option shall be the property of County at the termination of this License. County retains the right to require Licensee, at Licensee's cost, to remove all of Licensee's Improvements located on the License Area at the expiration or termination hereof. In the event that Licensee fails to remove said Licensee Improvements within fifteen (15) days following receipt of written notice from County to do so, such Licensee Improvements will be deemed abandoned, and Licensee shall lose all right, title and interest in and thereto, and County may elect (i) at Licensee's cost, to remove, demolish, or otherwise dispose of some or all of such items or (ii) sell or make use of any or all such items. Prior to any improvements, Licensee will notify County of the improvement, and County will confirm if it will own the improvement at the end of the License.

17. MECHANICS LIENS OR STOP-NOTICES (SRLic-2.6 S)

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

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

A. Record a valid release of lien, or

B. Procure and record a bond in accordance with sections 8424 or 9364 of the Civil Code, which frees the License Area from the claim of the lien or stop-notice and from any action brought to foreclose the lien.

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

18. OPERATIONAL REQUIREMENTS OF LICENSEE (SRLic-2.7 N)

Licensee shall, to the satisfaction of County, keep and maintain the License Area and all improvements of any kind in good condition and in substantial repair, at its sole cost and expense, normal wear and tear excepted. It shall be Licensee's responsibility to take all steps necessary or appropriate to maintain such a standard of condition and repair.

Licensee expressly agrees to maintain the License Area in a safe, clean, wholesome, and sanitary condition, to the reasonable satisfaction of County and in compliance with all applicable laws. Licensee further agrees to provide approved containers for trash and garbage and to keep the License Area free and clear of rubbish and litter. County shall have the right to enter upon and inspect the License Area upon forty-eight (48) hours' prior written notice to verify conformity with any terms and conditions of this License, including cleanliness and safety. Such inspection will not unreasonably interfere with Licensee's Use of the License Area.

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

If Licensee fails to maintain or make repairs or replacements as required herein, County may notify Licensee in writing of said failure. Should Licensee fail to correct the situation within five (5) business days thereafter, County may make or cause to be made the necessary correction, and the cost thereof, including, but not limited to, the cost of labor, materials, equipment, and administration, shall be paid by Licensee within ten (10) days of receipt of a statement of said cost from County. County may, at County's option, choose other remedies available herein, or by law.

19. INSURANCE (SRLic-2.8 S)

County Insurance: County shall maintain at all times general liability insurance coverage sufficient to cover Common Areas in minimum amounts of $1,000,000 per occurrence and $2,000,000 in aggregate.

Licensee Insurance: Licensee agrees to purchase all required insurance at Licensee's expense and to deposit with the County certificates of insurance, including all endorsements required herein, necessary to satisfy the County that the insurance provisions of this License have been complied with and to keep such insurance coverage and the certificates and endorsements therefore on deposit with the County during the entire term of this License. Licensee shall deposit the Certificate of Insurance with CEO Real Estate, consistent with the Notice clause, through electronic correspondence on or before the Effective Date of this License and annually throughout the Term, as necessary to: insurance.ceore@ocgov.com

Licensee agrees that Licensee shall not operate on the License Area at any time the required insurance is not in full force and effect as evidenced by a certificate of insurance and necessary endorsements or, in the interim, an official binder being in the possession of the County. In no cases shall assurances by Licensee, its employees, agents, including any insurance agent, be construed as adequate evidence of insurance. The County will only accept valid certificates of insurance and endorsements, or in the interim, an insurance binder as adequate evidence of insurance. Licensee also agrees that upon cancellation, termination, or expiration of Licensee's insurance, County may take whatever steps are necessary to interrupt any operation from or on the License Area until such time as the County reinstates the License.

If Licensee fails to provide the County with a valid certificate of insurance and endorsements, or binder at any time during the term of the License, County and Licensee agree that this shall constitute a material

breach of the License. Whether or not a notice of default has or has not been sent to Licensee, said material breach shall permit County to take whatever steps necessary to interrupt any operation from or on the License Area, and to prevent any persons, including, but not limited to, members of the general public, and Licensee's employees and agents, from entering the License Area until such time as the Chief Real Estate Officer is provided with adequate evidence of insurance required herein. Licensee further agrees to hold County harmless for any damages resulting from such interruption of business and possession, including, but not limited to, damages resulting from any loss of income or business resulting from the County's action.

Licensee may occupy the License Area only upon providing to County the required insurance stated herein and maintain such insurance for the entire term of this License. County reserves the right to terminate this License at any time Licensee's insurance is canceled or terminated and not reinstated within ten (10) days of said cancellation or termination. Licensee shall pay County a fee of two hundred dollars ($200.00) for processing the reinstatement of the License. Licensee shall provide to County immediate notice of said insurance cancellation or termination.

All contractors performing work on behalf of Licensee pursuant to this License shall obtain insurance subject to the same terms and conditions as set forth herein for Licensee or be covered by Licensee's insurance required under this section. Licensee shall not allow contractors or subcontractors to work if contractors have less than the level of coverage required by the County from the Licensee under this License. It is the obligation of the Licensee to provide written notice of the insurance requirements to every contractor and to receive proof of insurance prior to allowing any contractor to begin work within the License Area. Such proof of insurance must be maintained by Licensee through the entirety of this License and be available for inspection by a County representative at any reasonable time.

All self-insured retentions (SIRs) shall be clearly stated on the Certificate of Insurance. Any self-insured retention (SIR) in an amount in excess of Fifty Thousand Dollars ($50,000) shall specifically be approved by the County's Risk Manager, or designee, upon review of Licensee's current audited financial report. If Licensee's SIR is approved, Licensee, in addition to, and without limitation of, any other indemnity provision(s) in this License, agrees to all of the following:

1) In addition to the duty to indemnify and hold the County harmless against any and all liability, claim, demand or suit resulting from Licensee's, its agent's, employee's, or subcontractor's performance of this Agreement, Licensee shall defend the County at its sole cost and expense with counsel approved by Board of Supervisors against same; and

2) Licensee's duty to defend, as stated above, shall be absolute and irrespective of any duty to indemnify or hold harmless; and

3) The provisions of California Civil Code Section 2860 shall apply to any and all actions to which the duty to defend stated above applies, and the Licensee's SIR provision shall be interpreted as though the Licensee was an insurer and the County was the insured.

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

Qualified Insurer

The policy or policies of insurance under this License must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the most current edition

of the **Best's Key Rating Guide/Property-Casualty/United States or ambest.com).** It is preferred, but not mandatory, that the insurer be licensed to do business in the state of California (California Admitted Carrier).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, the CEO/Office of Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings.

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

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

Required Coverage Forms

The Commercial General Liability coverage shall be written on Insurance Services Office (ISO) form CG 00 01, or a substitute form providing liability coverage at least as broad.

The Business Auto Liability coverage shall be written on ISO form CA 00 01, CA 00 05, CA 00 12, CA 00 20, or a substitute form providing liability coverage at least as broad.

Required Endorsements

The Commercial General Liability policy shall contain the following endorsements, which shall accompany the Certificate of insurance:

1) An Additional Insured endorsement using ISO form CG 20 26 04 13 or a form at least as broad naming the ***County of Orange, its elected and appointed officials, officers, employees, agents*** as Additional Insureds. Blanket coverage may also be provided which will state- ***As Required By Written Agreement***.

2) A primary non-contributing endorsement using ISO form CG 20 01 04 13, or a form at least as broad, evidencing that the Licensee's insurance is primary and any insurance or self-insurance maintained by the County of Orange shall be excess and non-contributing.

The Workers' Compensation policy shall contain a waiver of subrogation endorsement waiving all rights of subrogation against the ***County of Orange, its elected and appointed officials, officers, agents, and employees***. Blanket coverage may also be provided which will state- ***As Required By Written Agreement.***

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

The Commercial Property policy shall contain a Loss Payee endorsement naming the County of Orange with respect to the County's financial interest when applicable.

Licensee shall notify County in writing within thirty (30) days of any policy cancellation and ten (10) days for non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the License, upon which the County may suspend or terminate this License.

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

Insurance certificates should be forwarded to the County address provided in the Clause 49 (NOTICES) below or to an address provided by the Chief Real Estate Officer. Licensee has ten (10) business days to provide adequate evidence of insurance or this License may be cancelled.

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

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

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

20. INDEMNIFICATION (SRLic-2.9 S)

Each Party (an "**Indemnifying Party**") hereby agrees to indemnify, hold harmless, and defend the other Party and the other Party's officers, agents, and employees (each and "**Indemnified Party**"), against any and all claims, losses, demands, damages, costs, expenses, or liability arising out of the Indemnifying Party's negligence, intentional misconduct, or breach in performing its obligations under this License.

If a Party is named as co-defendant, the Indemnifying Partying shall notify the other Party of such fact and shall represent the Indemnified Party, with counsel approved by the Indemnified Party, provided that such approval is not unreasonably withheld or delayed, in such legal action unless the Indemnified Party undertakes to represent itself as co-defendant in such legal action, in which event the Indemnifying Party shall pay the Indemnified Party's litigation costs, expenses, and attorneys' fees. If judgment is entered against the Parties because of the concurrent negligence of the Parties, , their officers, agents, or employees,

an apportionment of liability to pay such judgment shall be made by a court of competent jurisdiction. Neither Party shall request a jury apportionment.

21. HAZARDOUS MATERIALS (SRLic-3.0 S) – *Intentionally Omitted*

22. BEST MANAGEMENT PRACTICES (SRLic-3.1 S)

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

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

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

BMP Fact Sheets that apply to uses authorized under this License include the BMP Fact Sheets that are attached hereto and by reference made a part hereof as Exhibit D, which exhibit is attached hereto and by reference made a part hereof. These BMP Fact Sheets may be modified during the term of the License; and the Director of Orange County Public Works or Licensor shall provide Licensee with any such modified BMP Fact Sheets. Licensee, agents, contractors, representatives, and employees and all persons authorized by Licensee to conduct activities on the License Area shall, throughout the term of this License, comply with the BMP Fact Sheets as they exist now or are modified, and shall comply with all other requirements of the Stormwater Permits, as they exist at the time this License commences or as the Stormwater Permits may be modified. The BMPs applicable to uses authorized under this License must be performed as described within all applicable BMP Fact Sheets.

Licensee may propose alternative BMPs that meet or exceed the pollution prevention performance of the BMP Fact Sheets. Any such alternative BMPs shall be submitted to the Director of Orange County Public Works or Licensor for review and approval prior to implementation.

The Chief Real Estate Officer or authorized representative may enter the License Area and Access Area and/or review Licensee's records at any time to assure that activities conducted on the License Area and

Access Area comply with the requirements of this Clause 22 (BEST MANAGEMENT PRACTICES). Licensee may be required to implement a self-evaluation program to demonstrate compliance with the requirements of this Clause 22.

23. WATER QUALITY MANAGEMENT PLAN (SRLic-3.2 S) – *Intentionally Omitted*

24. LIMITATION OF THE LICENSE (SRLic-3.3 S)

This License and the rights and privileges granted Licensee in and to the License Area are subject to all covenants, conditions, restrictions, and exceptions of record or apparent from a physical inspection of the License Area. Nothing contained in this License or in any document related hereto shall be construed to imply the conveyance to Licensee of rights in the License Area which exceed those owned by County, or any representation or warranty, either express or implied, relating to the nature or condition of the License Area or County's interest therein. Licensee has accepted the License Area in its "as is"/"where is" condition.

25. UNLAWFUL USE (SRLic-3.4 S)

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

Further, all uses of the License Area by Licensee shall be conducted in accordance with all applicable law, ordinance, or regulation, including but not limited to any "**Environmental Laws**." "Environmental Laws" means any federal, state, or local statute, ordinance, rule, regulation, order, consent decree, judgment, or common-law doctrine, and provisions and conditions of permits, licenses, and other operating authorizations relating to (A) pollution or protection of the environment, including natural resources, (B) exposure of persons, including employees, to Hazardous Materials or other products, raw materials, chemicals, or other substances, (C) protection of the public health or welfare from the effects of by-products, wastes, emissions, discharges, or releases of chemical substances from industrial or commercial activities, or (D) regulation of the manufacture, use, or introduction into commerce of chemical substances, including, without limitation, their manufacture, formulation, labeling, distribution, transportation, handling, storage, and disposal.

26. RESERVATIONS TO COUNTY (SRLic-3.5 S) – *Intentionally Omitted*

27. NO ASSIGNMENT, SUBAGREEMENTS (SRLic-3.6 N)

The License granted hereby is personal to Licensee and any assignment of said License by Licensee, voluntarily or by operation of law, shall automatically terminate the License granted hereby. Sublicenses or subleases are not authorized under this License and any attempt by Licensee to create any such sublicense or sublease shall be null and void and shall automatically terminate the License.

28. TAXABLE POSSESSORY INTEREST ASSESSMENTS (SRLic-3.7 S)

Should this License create any possessory interest which is subject to the payment of taxes levied on such interest, it is understood and agreed that all assessments associated with said taxable possessory interest shall be the full responsibility of the Licensee, and Licensee shall cause said assessments to be paid promptly.

29. LABOR CODE COMPLIANCE (SRLic-3.8 S)

Licensee acknowledges and agrees that all improvements or modifications required to be performed for any such future improvements or modifications performed by Licensee shall be governed by, and performed in accordance with, the provisions of Article 2 of Chapter 1, Part 7, Division 2 of the Labor Code of the State of California (Sections 1770, et seq.), as applicable. These provisions may be applicable to improvements or modifications costing more than $1,000, unless an exception applies, including but not limited to the exception to the definition of public works under § 1720.2.

Pursuant to the provisions of Section 1773 of the Labor Code of the State of California, Licensee shall comply with the general prevailing rate of per diem wages and the general prevailing rate for holiday and overtime work in the locality applicable to this License for each craft, classification, or type of workman needed to execute the aforesaid improvements or modifications. The rates are available at the following website: http://www.dir.ca.gov/dlsr/DPreWageDetermination.htm from the Director of the State Department of Industrial Relations. Licensee shall post a copy of such wage rates at the job site and shall pay the adopted prevailing wage rates at all times for all improvements or modifications to be completed for County within the License Area. Licensee shall comply with the provisions of Sections 1775 and 1813 of the Labor Code.

As required by applicable law, Licensee shall maintain certified payroll records for all workers that will be assigned to the improvements or modifications. Said payroll records shall contain, but not be limited to, the complete name, address, telephone number, social security number, job classification, and prevailing wage rate for each worker. Upon reasonable request from the County, Licensee shall provide the County updated certified payroll records for all workers that shall include, but not be limited to, the weekly hours worked, prevailing hourly wage rates, and total wages paid.

If Licensee neglects, fails, or refuses to provide said payroll records to the County, upon reasonable request, such occurrence shall constitute an event of default of this License and County may, notwithstanding any other termination provisions contained herein terminate this License upon written notice to Licensee.

30. RIGHT TO WORK AND MINIMUM WAGE LAWS (SRLic-3.9 S)

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

Pursuant to the United States of America Fair Labor Standard Act of 1938, as amended, and State of California Labor Code, Division 2, Parts 4 and 7, Licensee shall pay no less than the greater of the Federal or California Minimum Wage to all its employees that directly or indirectly service the License Area, in any manner whatsoever. Licensee shall require and verify that all its contractors or other persons servicing the License Area on behalf of the Licensee also pay their employees no less than the greater of the Federal or California Minimum Wage.

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

Notwithstanding the minimum wage requirements provided for in this Clause 30, Licensee, where applicable, shall comply with the prevailing wage and related requirements pursuant to the provisions of Section 1773 of the Labor Code of the State of California.

31. SIGNS (SRLic-4.0 S)

Licensee agrees not to construct, maintain, or allow any signs, banners, flags, etc., upon License Area except as approved by the Chief Real Estate Officer. Unapproved signs, banners, flags, etc., may be removed.

32. AUTHORITY (SRLic-4.1 S)

The persons executing the License below on behalf of County or Licensee each warrant that they have the power and authority to bind County or Licensee to this License.

33. LICENSE ORGANIZATION (SRLic-4.2 S)

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

34. AMENDMENTS (SRLic-4.3 S)

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

35. PARTIAL INVALIDITY (SRLic-4.4 S)

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

36. WAIVER OF RIGHTS (SRLic-4.5 S)

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

37. GOVERNING LAW AND VENUE (SRLic-4.6 S)

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

38. ATTORNEYS' FEES (SRLic-4.7 S)

In the event of a dispute between County and Licensee concerning claims arising out of this License, or in any action or proceeding brought to enforce or interpret any provision of this License or where any provision hereof is validly asserted as a defense, each Party shall bear its own attorneys' fees and costs.

39. TIME OF ESSENCE (SRLic-4.8 S)

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

40. INSPECTION (SRLic-4.9 N)

County or its authorized representative shall have the right upon forty-eight (48) hours' prior notice to inspect the operation to determine if the provisions of this License are being complied with.

41. INSPECTION OF LICENSE AREA BY A CERTIFIED ACCESS SPECIALIST (SRLic-5.0 S)

A Certified Access Specialist (CASp) can inspect the subject License Area and determine whether the subject License Area complies with all of the applicable construction-related accessibility standards under state law. Although state law does not require a CASp inspection of the subject License Area, the commercial property owner or lessor may not prohibit the lessee or tenant from obtaining a CASp inspection of the subject License Area for the occupancy or potential occupancy of the Licensee, if requested by the Licensee. The Parties shall mutually agree on the arrangements for the time and manner of the CASp inspection, the payment of the fee for the CASp inspection, and the cost of making any repairs necessary to correct violations of construction-related accessibility standards within the License Area.

Pursuant to California Civil Code 1938, County hereby represents that the License Area has not undergone an inspection by a certified access specialist and no representations are made with respect to compliance with accessibility standards. If it is determined during this tenancy that a violation of handicapped access laws (including the Americans with Disabilities Act) exists at the License Area, County shall correct such non-compliance at County's cost.

42. PERMITS AND LICENSES (SRLic-5.1 N)

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

43. PAYMENT CARD COMPLIANCE (SRLic-5.2 S)

Should Licensee conduct credit/debit card transactions in conjunction with their business with the County, on behalf of the County, or as part of the business that they conduct, Licensee covenants and warrants that it is currently Payment Card Industry Data Security Standard ("**PCI DSS**") and Payment Application Data Security Standard ("**PA DSS**") compliant and will remain compliant during the entire duration of this

License. Licensee agrees to immediately notify County in the event Licensee should ever become noncompliant, and will take all necessary steps to return to compliance and shall be compliant within ten (10) days of the commencement of any such interruption.

44. NONDISCRIMINATION (SRLic-5.3 N)

Parties agree not to discriminate against any person or class of persons by reason of sex, age, race, color, creed, physical handicap, or national origin in employment practices and in the activities conducted pursuant to this License. Licensee shall make its accommodations and services available to the public on fair and reasonable terms.

45. CONDITION OF LICENSE AREA UPON TERMINATION (SRLic-5.4 S)

Except as otherwise agreed to herein or in subsequent approval in writing by Licensor, upon termination of this License, Licensee shall redeliver possession of said License Area to County in substantially the same condition that existed immediately prior to Licensee's entry thereon, reasonable wear and tear, flood, earthquakes, war, and any act of war excepted.

46. DISPOSITION OF ABANDONED PERSONAL PROPERTY (SRLic-5.5 S)

If Licensee abandons the License Area or is dispossessed thereof by process of law or otherwise, title to any personal property belonging to Licensee and left on the License Area ten (10) days after such event shall be deemed, at County's option, to have been transferred to County. County shall have the right to remove and to dispose of such personal property without liability therefor to Licensee or to any person claiming under Licensee and shall have no need to account therefor.

47. PUBLIC RECORDS (SRLic-5.6 N)

Any and all written information submitted to and/or obtained by each Party from the other Party or any other person or entity having to do with or related to this License and/or the License Area, either pursuant to this License or otherwise, at the option of the receiving Party, may be treated as a public record open to inspection by the public pursuant to the California Public Records Act, Government Code sections 7920.000, et seq. as now in force or hereafter amended, or any Act in substitution thereof, or otherwise made available to the public, and each Party hereby waives, for itself, its agents, employees, and any person claiming by, through or under Licensee, any right or claim that any such information is not a public record or that the same is a trade secret or confidential information and hereby agrees to indemnify and hold the Party disclosing the written information under the California Public Records Act harmless from any and all claims, demands, liabilities, and/or obligations arising out of or resulting from a claim by the disclosing Party or any third party that such information is a trade secret, or confidential, or not subject to inspection by the public, including without limitation reasonable attorneys' fees and costs.

48. RELATIONSHIP OF PARTIES (SRLic-5.7 S)

The relationship of the Parties hereto is that of Licensor and Licensee, and it is expressly understood and agreed that County does not in any way or for any purpose become a partner of or a joint venture with Licensee in the conduct of Licensee’s business or otherwise, and any provisions of this License and the agreements relating to money payable hereunder are included solely for the purpose of providing a method by which such payments are to be measured and ascertained.

49. NOTICES (SRLic-5.8 S)

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

To: County	To: Licensee
County of Orange, CEO Real Estate 400 W. Civic Center Dr., 5th Floor Santa Ana, CA 92701 Attention: Chief Real Estate Officer	CalOptima Health 505 City Parkway West, Orange, CA 92868 Attention: Tiffany Kaaiakamanu, Community Relations Manager

Any and all insurance related mail shall include the License number and project name and Licensee shall mail all insurance certificates and insurance-related correspondence to: insurance.ceore@ocgov.com.

50. ATTACHMENTS TO LICENSE (SRLic-6.0 S)

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

I. EXHIBITS

Exhibit A – License Area Description
Exhibit B – License Area Depiction
Exhibit C – Best Management Practices

This License may be executed in one or more counterparts, each of which will be deemed an original signature but all of which together will constitute one and the same instrument.

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

APPROVED AS TO FORM:

OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By:_____
Deputy

LICENSEE

CALOPTIMA HEALTH, a Public Agency

By:_____
Name, Title

By: _____
Name, Title

RECOMMENDED FOR APPROVAL:

SOCIAL SERVICES AGENCY

By:_____
Director of Administrative Services

COUNTY EXECUTIVE OFFICE

By:_____
Real Estate Manager

*** Pursuant to the requirements of California Corporations Code section 313, one of the following two methods must be used by a corporation when it enters into a contract with the County: Two people must sign the document. One of them must be the chairman of the board, the president or any vice president. The other must be the secretary, any assistant secretary, the chief financial officer or any assistant treasurer. One corporate officer may sign the document, providing that written evidence of the officer's authority to bind the corporation with only his or her signature must be provided. This evidence would ideally be a corporate resolution.

COUNTY

COUNTY OF ORANGE

By: _____
Thomas A. Miller, Chief Real Estate Officer
County Executive Office
Per Resolution No. 23-153 and Minute Order dated December 5, 2023, of the Board of Supervisors

Date:_____

EXHIBIT A

LICENSE AREA DESCRIPTION

Agency: Social Services Agency
Project: County Community Service Center Brea

All the License Area shown crosshatched on a plot plan marked Exhibit B, attached hereto and made a part hereof, being approximately one hundred thirteen (113) rentable square feet of exclusive office space, within commonly known as Suites 100 and 125, collectively the License Area as shown on Exhibit B, located on the first (1st) floor of that certain three-story building located at 675 Placentia Avenue, in the city of Brea, County of Orange, State of California, together with non-exclusive, in common use of the Common Area and one (1) parking.

NOT TO BE RECORDED

EXHIBIT B

LICENSE AREA DEPICTION



675 Placentia Avenue, Brea, CA 92821

EXHIBIT B (CONTINUED)

LICENSE AREA DEPICTION



EXHIBIT B (CONTINUED)

LICENSE AREA DEPICTION

Office #1042 - One (1) office, approximately 113 rentable square feet, located on the first floor of County Property located at 675 Placentia Avenue, Suite 100-125, Brea, CA 92821

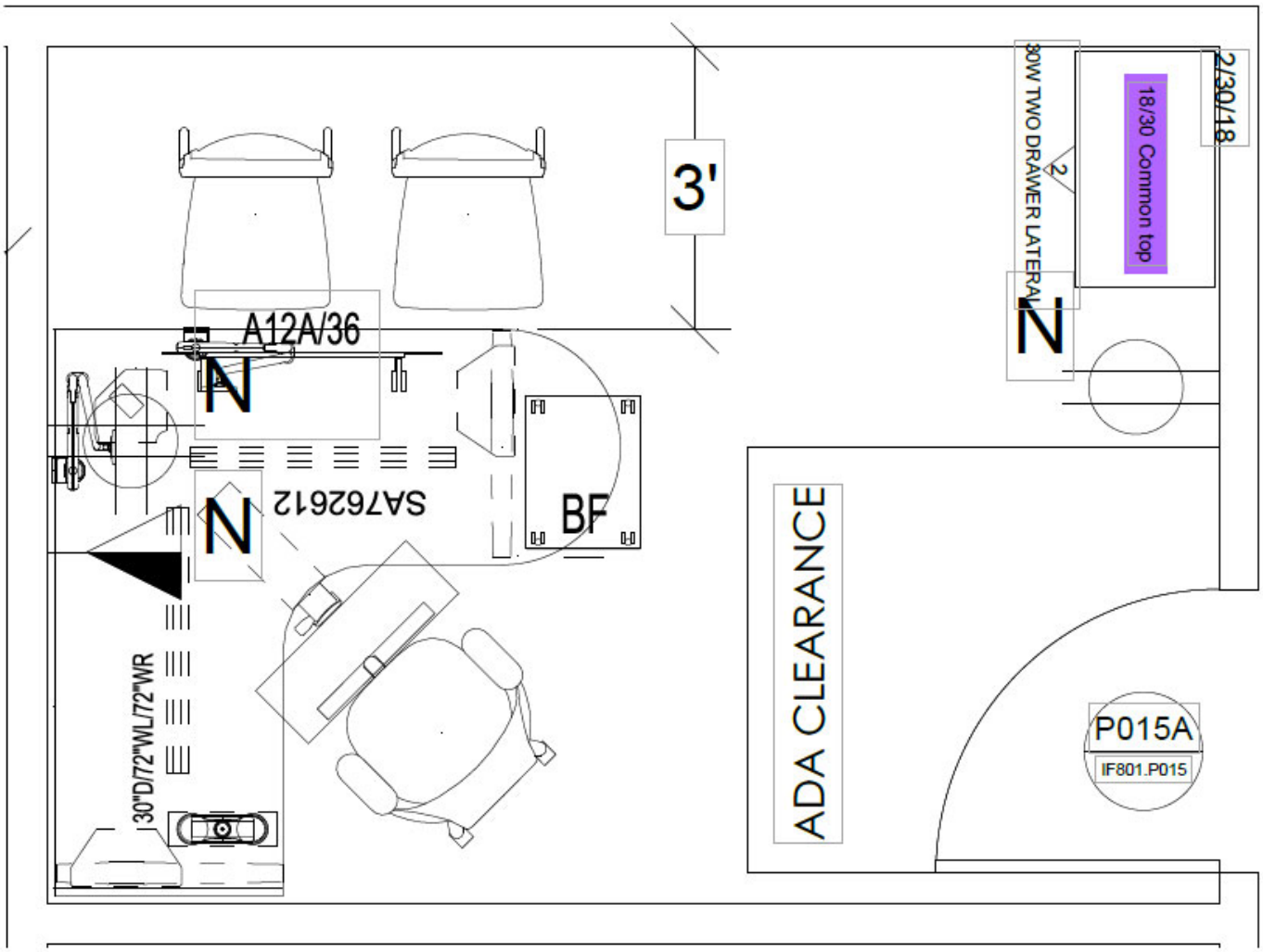


EXHIBIT C

BEST MANAGEMENT PRACTICES ("BMP" FACT SHEETS)

Licensee shall be responsible for implementing and complying with all BMP Fact Sheet requirements that apply to Licensee's operations. Licensee is to be aware that the BMP clause within this License, along with all related BMP Exhibits, may be revised, and may incorporate more than what is initially being presented in this License. Licensee shall be notified of any such changes according to Clause 22 (BEST MANAGEMENT PRACTICES) and shall have the right to immediately terminate this License if Licensee does not agree to such changes.

Suggested BMPs Fact Sheets are shown on the following list below and can be found at: http://ocwatersheds.com/documents/bmp:

- IC3 Building Maintenance
- IC4 Carpet Cleaning
- IC5 Concrete & Asphalt Production, Application, & Cutting
- IC6 Contaminated or Erodible Surface Areas
- IC7 Landscape Maintenance
- IC9 Outdoor Drainage from Indoor Areas
- IClO Outdoor Loading/Unloading of Materials
- IC11 Outdoor Process Equipment Operations & Maintenance
- IC12 Outdoor Storage of Raw Materials, Products, & Containers
- IC13 Over Water Activities
- IC14 Painting, Finishing, & Coatings of Vehicles, Boats, Buildings, & Equipment
- IC15 Parking & Storage Area Maintenance
- IC17 Spill Prevention & Cleanup
- IC21 Waste Handling & Disposal
- IC22 Eating & Drinking Establishments
- IC23 Fire Sprinkler Testing/Maintenance
- IC24 Wastewater Disposal Guidelines



The County Community Service Center

The County Community Service Center (CCSC) is a one-stop-shop. Visitors can receive services from the County of Orange Social Services Agency, OC Health Care Agency and CalOptima Health. Available services include:

Public Safety Net Services

- Apply for benefits like money for groceries, health insurance, cash aid and more
- Learn how services help patients take control of their health care decisions

Behavioral and Mental Support Services

- Connect to supportive services that impact mental wellness

OC Workforce Solutions (Third Floor)

- Employment resources for job seekers, youth and businesses

Referrals for:

- Housing
- Children's services, such as childcare and educational services

Connections and referrals to other government agencies and community-based organizations and resources

675 Placentia Ave., Suite 100
Brea, CA 92821
Monday through Friday
8 a.m. to 5 p.m.
(714) 834 - 7500

***Staff are available to provide assistance in Vietnamese and Spanish.**

CalOptima Health

COUNTY OF ORANGE CALIFORNIA
OC Social Services Agency
Our Community, Our Commitment

OC Housing Authority

OC health CARE AGENCY

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contacts

Carmen Katsarov, LPCC, CCM, Executive Director Behavioral Health Integration, (714) 796-6168
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Recommended Actions

1. Update the funding category from "CalOptima Health Program Support Positions" to "CalOptima Health Program Support" to include program support positions and ongoing activities, programs, and events that support student and youth behavioral health.
2. Authorize the Chief Executive Officer, or designee, to execute a service agreement in an amount up to $49,500 with *Cognoa* to perform autism diagnostic services at the diagnosis day event in 2025 in accordance with CalOptima Health Policy GA.5002: Purchasing.

Background

The Student Behavioral Health Incentive Program (SBHIP), a Department of Health Care Services (DHCS) 3-year state initiative (2022-2024), provided $25,459,676 in incentive payments to CalOptima Health. Throughout the program, CalOptima Health and its SBHIP partners (Hazel Health, Western Youth Services, CHOC, OC Department of Education and their 29 public school districts) successfully met the program's objectives. On April 24, 2025, CalOptima Health received the remaining $3.18 million of the $25,459,676. As of this writing, CalOptima Health has received the full amount of eligible SBHIP earnings from DHCS.

On March 6, 2025, the CalOptima Health Board of Directors (Board) authorized modifications to the SBHIP Funding Plan to support SBHIP Phase Two, including extending the Memorandum of Understanding with and funding to Hazel Health to provide telehealth services through the 2025-26 school year.

Discussion

CalOptima Health along with its SBHIP partners, continues to assess the ongoing behavioral health needs of the children and youth in Orange County. Staff will continue to present items to the Board for approval to spend down the remaining funds of the SBHIP Incentive Funding Plan. In this COBAR, staff is proposing two actions with no change to the overall funding amount of $25.5 million.

1. The modified SBHIP Incentive Funding Plan – Phase Two included a funding category, "CalOptima Health Program Support Positions" for one (1) internal contracting position to manage contracting activities for SBHIP. Staff now recommends updating the funding category to "CalOptima Health Program Support," to fund internal Behavioral Health Integration position(s) to support ongoing coordination and administrative responsibilities of SBHIP Phase

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Two, and support other events, activities, or programs that support student and youth behavioral health, through June 30, 2026.

2. Staff proposes to support a diagnosis day event in 2025 to address a backlog of CalOptima Health children waiting for autism evaluations and requests authority to execute a service agreement in an amount up to $49,500 with *Cognoa* to perform autism diagnostic services at the event.

   CalOptima Health learned about the backlog during recent meetings of Detect & Connect OC, a cross-sector collaborative group between 20 Orange County agencies organizations, including First 5 OC, Orange County Regional Center, CHOC and CalOptima Health. Detect & Connect OC is dedicated to working together to ensure all children in Orange County (i) receive timely, recommended developmental screenings and (ii) are connected to resources and interventions as early as possible. Waitlists for children needing autism evaluations are not unique to Orange County and occur across California and other states due to a workforce shortage of physicians and other professionals with this training and expertise.

   At a recent Detect & Connect OC meeting in 2025, *Cognoa* presented its innovative technology Canvas Dx™, the first FDA-authorized diagnostic for autism. To address the current backlog of CalOptima Health members, the idea of a diagnosis day event to be held in 2025 was discussed. Staff plan to execute a service agreement with *Cognoa* as a micro purchase in accordance with Section II.C.2. Informal Procurement of CalOptima Health Policy GA.5002: Purchasing. Different Orange County organizations and agencies will be present at the event, including CalOptima Health behavioral health staff to connect members to services after diagnosis.

As reference, please see the table below for the updated SBHIP Incentive Funding Plan. There are no changes to the previously approved funding amounts.

Entity	Board-approved SBHIP Funding (Up to Amounts)
CHOC	$2.1 million
WYS	$802,000
OCDE and the 29 Orange County Public School Districts	$10.0 million
Hazel Health	$11.9 million
CalOptima Health Program Support	$521,500
California School-Based Health Alliance Sponsorship Event April 28-29, 2025	$100,000
Total:	**$25.5 million**

Fiscal Impact

The recommended actions have no additional fiscal impact beyond what has previously been approved through separate Board actions.

Rationale for Recommendation

CalOptima Health recommends proceeding with the requested actions to continue SBHIP Phase Two activities supporting its continued commitment to youth behavioral health and wellness.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Previous Board Action dated Mach 6, 2025, "Authorize Actions Related to the Student Behavioral Health Incentive Program Funding Strategy"

/s/ Michael Hunn *05/30/2025*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken March 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

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

Contacts

Carmen Katsarov, LPCC, CCM, Executive Director Behavioral Health Integration, (714) 796-6168
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Recommended Actions

1. Authorize modification of the previously Board-approved Student Behavioral Health Incentive Program (SBHIP) Incentive Funding Plan to support SBHIP Phase Two:
    a. Reallocate to Hazel Health up to $3.5 million from the Notice of Funding Opportunity (grants to serve Medi-Cal school-aged children and youth in Orange County).
    b. Allocate up to $471,000 in unallocated funding:
        i. Up to $371,000 for the internal Contracting Program Support Position to manage the contracting activities supporting SBHIP.
        ii. Up to $100,000 for the California School-Based Health Alliance, 2025 School Health Conference sponsorship.
2. Authorize the Chief Executive Officer, or designee, to amend the Memorandum of Understanding with Hazel Health to extend the end date to June 30, 2026.
3. Approve expenditures of up to $100,000 and staff participation at the 2025 School Health Conference on April 28-29, 2025, in Anaheim;
    a. Make a finding that such an expenditure is for a public purpose and in furtherance of CalOptima Health′s mission and statutory purpose; and
    b. Authorize the Chief Executive Officer to execute agreements as necessary for the event and expenditures.

Background

The SBHIP is a Department of Health Care Services (DHCS) 3-year state initiative. The Board of Directors (Board) approved three previous actions related to SBHIP. On December 20, 2021, the Board authorized the Chief Executive Officer (CEO) to submit a letter of intent to DHCS by January 31, 2022, for CalOptima Health's intent to participate in the 3-year SBHIP. On August 4, 2022, the Board authorized the CEO, with the assistance of legal counsel, to execute memorandums of understanding and contracts with SBHIP grantees. On May 4, 2023, the Board authorized the CEO to allocate and distribute the SBHIP incentive payment funds to the SBHIP partners Hazel Health, Western Youth Services (WYS), Children's Hospital of Orange County (CHOC), and Orange County Office of Education (OCDE) and its 29 Orange County Public School Districts.

Through the SBHIP, DHCS determined that CalOptima Health could receive incentive payments of up to $25,459,676. Since the program's inception, CalOptima Health and its SBHIP partners have been completing the expected SBHIP objectives and activities. As of this writing, approximately $22.3 million has been received, with the remaining $3.1 million anticipated this fiscal year.

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Discussion

Modification to SBHIP Incentive Funding Plan – Phase Two

As staff returns to the Board with a program update and recommendations on the remaining unallocated and unused SBHIP funds during the 3 years of SBHIP, per DHCS' directive, CalOptima Health and the SBHIP partners have continued to reassess the ongoing needs of the students. Staff proposes the following modification to the SBHIP Incentive Funding Plan to continue to support the collaborative partnerships and investments implemented during SBHIP. The changes to the funding plan do not cause an increase or decrease in the overall DHCS-determined eligible earnings of up to $25,459,676.

Entity	5/4/23 Board-approved SBHIP Funding	03/06/25 Proposed Board-action	Proposed Modified Funding
CHOC	Up to $2.1M	-	Up to $2.1M
WYS	Up to $802K	-	Up to $802K
OCDE and the 29 Orange County Public School Districts	Up to $10.0M	-	Up to $10.0M
Hazel Health	Up to $8.4M	Up to $3.5M	Up to $11.9M
CalOptima Health Program Support Positions	Up to $200K	Up to $371K	Up to $571K
Notice of Funding Opportunity (grants to serve Medi-Cal school-aged children and youth in Orange County)	Up to $3.5M	Remove	0
Remaining Unallocated Budget	Up to $471K	Allocate	0
California School-Based Health Alliance Sponsorship Event April 28-29, 2025	-	Up to $100K	Up to $100K
Total:	**$25.5M**	**$4.0M**	**$25.5M**

Hazel Health

The school districts and OCDE confirmed to staff the need to continue services through Hazel Health. This action will provide more time for school districts that have deployed Hazel Health to increase utilization of the services and time for the other districts to engage Hazel Health to activate telehealth services. Staff requests the Board reallocate to Hazel Health up to $3.5 million from grants to serve Medi-Cal school-aged children in Orange County in order for Hazel Health to continue providing telehealth services during the 2025-2026 school year. The reallocation will provide further time for analysis of utilization data to determine continuance of Hazel Health services after the 2025-2026 school year, and aligns with the SBHIP biquarterly reports already submitted to and approved by DHCS. To implement the extension, staff will pursue an amendment of the Hazel Health MOU to extend the end date to June 30, 2026.

California School-Based Health Alliance, 2025 School Health Conference

Staff received a request on September 6, 2024, inviting CalOptima Health to be the presenting sponsor of the 2025 School Health Conference - The Power of Partnerships to be held on April 28 & 29, 2025.

The event is hosted by the California School-Based Health Alliance (CSHA), a statewide nonprofit organization that advances increased access to primary and behavioral health services for the state's public school students. Per CalOptima Health Policy AA.1223 - Participation in Community Events by External Entities, financial requests from qualified external entities for eligible events valued at more than $25,000 require Board approval. Since the request of a $100,000 allocation for sponsorship exceeds this amount, staff seek Board approval to participate.

This sponsorship will position CalOptima Health to support behavioral health services in Orange County schools and disseminate learnings of the SBHIP partnerships and achievements to attendees from schools in Orange County and around the state. CSHA began participating in CalOptima Health's SBHIP Provider convenings in the fall of 2024, leveraging their subject matter expertise and best practices in delivering high-quality, comprehensive school-based health care. CalOptima Health's sponsorship will provide an opportunity to model the valuable partnerships CalOptima Health built with Orange County stakeholders so the anticipated 800 attendees can learn and carry out similar work in their communities as they work to improve access to health and behavioral health services in schools. CalOptima Health will be provided with exclusive benefits as a presenting sponsor, including being prominently featured in all conference promotional materials, leading the Orange County regional breakout session with local stakeholders, and providing welcome remarks at the conference opening and reception.

Program Support Positions: Staff requests an allocation of up to $371,000 to continue to fund an internal Contracting Program Support Position to manage the contracting activities supporting SBHIP.

The following provides an update on the spending of the SBHIP Funding Plan as of December 31, 2024.

SBHIP Funding Update	Amount
Spend as of December 31, 2024	$15.4M
As of December 31, 2024, SBHIP allocated funds to be distributed to the SBHIP Partners	$6.1M
Unallocated/unused funds	$4.0M
Total:	**$25.5M**

Fiscal Impact

The recommended actions will be funded by a reallocation of up to $3.5 million and an allocation of up to $471,000 in SBHIP incentive payment funding and has no additional net fiscal impact.

Rationale for Recommendation

CalOptima Health recommends proceeding with the requested actions to continue SBHIP Phase Two activities supporting its continued commitment to youth behavioral health and wellness.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. SBHIP Update
2. CalOptima Health policy AA.1223 - Participation in Community Events by External Entities
3. Covered Entity

4. 12/20/21 COBAR: Approve action related to the Student Behavioral Health Incentive Program
5. 08/04/22 COBAR: Approve action related to the Student Behavioral Health Incentive Program
6. 05/04/23 COBAR: Approve action related to the Student Behavioral Health Incentive Program Funding Strategy_Rev

/s/ Michael Hunn *02/28/2025*
Authorized Signature **Date**

Attachment: SBHIP Update

OCDE and the 29 Orange County Public School Districts

- Increased the behavioral health school personnel/workforce by achieving the SBHIP 10-20% goal.
- 17 of the 29 public school districts have either: 1) expanded their use of universal screeners, 2) purchased and piloted the screener, or 3) renewed contracts with current screener publishers.
- Through SBHIP, many of the public-school districts made a significant improvement in their IT infrastructure/systems from previous manual processes to sophisticated systems. 27 of the 29 public-school districts reported progress towards utilizing electronic health record systems or exploring other systems for tracking and documentation.

CHOC

- SBHIP-funded WellSpaces:
  - Increased the number of WellSpaces in the Orange County public school districts by installing the 10 expected SBHIP-funded WellSpaces.
  - Overall, including the SBHIP-funded WellSpaces, the number of WellSpaces has significantly increased from 19 at the start of SBHIP to 54 at the close of the SBHIP program timeline.
- The School Reintegration Program:
  - A full-time licensed social worker was hired to support the school reintegration program launched in late 2023.
  - The program's purpose is to provide a service to help children reintegrate back into school after a mental health crisis, with family permission and help schools provide an optimal environment to support the child and family.
- The Mental Health Crisis Clinic (MHCC):
  - MHCC opened to community and schools in February 2024.
  - Students with identified suicidal ideation and no current therapist can be seen within 72 hours for an initial evaluation by a mental health clinician and up to three (3) additional stabilization sessions while awaiting connection to long term community services.
- The Deaf or Hard-of-Hearing Consultative Services:
  - In late 2023, CHOC hired a deaf and hard of hearing psychologist for the program, who provides consultative support at no cost to the public-school districts.
  - The psychologist's consultative service identifies mental health needs and shares best practices for deaf and hard of hearing students, ensuring equitable care for this student population.
- The Autism Comprehensive Care Program:
  - Projected to start by 2nd quarter 2025.
  - The pilot program plans to serve students between the ages of 12-17 with Autism and acute/severe mental health concerns such as depression, suicidal ideation,

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anxiety, etc.

Western Youth Services (WYS)

- In August 2024, WYS deployed an on-demand virtual Behavioral Health Curriculum library for the 29 Orange County public school districts
- Also, WYS is conducting in-person trainings and post-training consultative support.

Hazel Health (telehealth counseling services)

- Launched in January 2024, 19 of the 29 public school districts implemented Hazel Health in 340 of the 586 public schools, which account for 260,121 students who now have access to Hazel Health.
- The counseling services are delivered on school sites or in the student's home.

Policy:	AA.1223
Title:	**Participation in Community Events by External Entities**
Department:	Communications
Section:	Community Relations
CEO Approval:	*/s/ Michael Hunn 12/16/2024*
Effective Date:	02/02/2017
Revised Date:	12/01/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes guidelines for CalOptima Health's Participation in community events, programs, projects, and activities involving external entities.

II. POLICY

A. CalOptima Health recognizes the value of partnering with external entities to provide additional health care related services to benefit the local community, while still upholding its fiscal responsibilities as a steward of public funds. Requests for CalOptima Health's Participation in community events involving external entities, financially, or otherwise, shall be approved only if aligned with CalOptima Health's mission, vision and values.

B. An external entity may be eligible for CalOptima Health's Participation in its event if the entity is a community-based, non-profit organization, health care partner, public or government entity (collectively, "external entities") that serves CalOptima Health members or supports CalOptima Health's mission, vision and values. Religious organizations are not eligible for CalOptima Health's Participation unless the event is open to the general public and is for a non-sectarian purpose.

C. The expenditure of CalOptima Health's funds shall only be made for a direct and primary public purpose within CalOptima Health's authority and jurisdiction. Absent a legitimate and direct public purpose within CalOptima Health's authority and jurisdiction, CalOptima Health shall not use public funds to make monetary contributions to external entities solely for the purpose of goodwill, showing support, networking, public relations, or relationship building. External entities may not use CalOptima Health's Participation in any manner to donate, or endorse, political candidates to elected office, or to support/oppose a position on proposed legislation, ballot initiative, or proposition.

D. CalOptima Health's Participation shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima Health representative;

2. A presentation, or panel presentation, by a CalOptima Health representative;

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3. A booth, or table, designated for CalOptima Health at the event to distribute CalOptima Health information to members and/or potential members who could be enrolled in any of CalOptima Health's programs; or

4. Other opportunity to promote CalOptima Health's services and increase awareness about CalOptima Health.

E. There may be circumstances where financial Participation for external entities, such as charitable organizations, or activities (*e.g.*, United Way), may be permitted based on a finding by the CalOptima Health Board of Directors that the request for financial Participation falls within CalOptima Health's authority and purpose, and meets one (1) of the following criteria:

1. The financial Participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima Health provides; or

2. There is an identifiable benefit to CalOptima Health and/or its members.

F. The expenditure of CalOptima Health funds and the use of resources, staff time, and CalOptima Health facilities shall not be inconsistent with, or in conflict with, CalOptima Health's obligations under applicable state and federal laws and contracts.

G. Requests for Participation by CalOptima Health in an event proposed by an external entity shall require approval as follows:

1. Requests for Participation, other than financial contributions, such as hosting booths at health fairs, conducting education programs and presentations, or organizing community/town hall meetings:

a. Requests for non-financial Participation from external entities shall be submitted no less than fourteen (14) calendar days in advance of the date of the event.

b. The Chief Executive Officer (CEO) or his/her designee is authorized to approve non-financial requests from external entities for community/member-oriented events that meet the eligibility requirements as provided in this Policy.

c. Non-financial Participation requests from external entities for community/member-oriented events such as health fairs, educational events, and/or community/town hall forums shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima Health members and/or potential members that could be enrolled in any of CalOptima Health's programs, or be in furtherance of CalOptima Health's mission, vision & values, programs, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, and description of CalOptima Health's Participation in the event.

2. Requests for financial Participation, up to and including, a cumulative value of twenty-five thousand dollars ($25,000) per organization per fiscal year, which shall include all materials and supplies:

    a. Requests for financial Participation in an amount up to and including twenty-five thousand dollars ($25,000) per organization per fiscal year, inclusive of all materials and supplies, shall be submitted no less than twenty-one (21) calendar days in advance of the date of the event, or if in a shorter amount of time, at the discretion of the CEO, or his/her designee, so long as such request is submitted to the CEO, or his/her designee, in a reasonable and sufficient amount of time so that CalOptima Health can complete a meaningful review and evaluation of the request.

    b. The CEO or his/her designee is authorized to approve requests for financial Participation for qualifying external entities and events for a cumulative amount of up to and including twenty-five thousand dollars ($25,000) per organization per fiscal year, subject to availability of budgeted funds.

    c. All requests for financial Participation to CalOptima Health from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

        i. Member interaction/enrollment – The activity shall include Participation from CalOptima Health members and/or potential members that could be enrolled in any of CalOptima Health's programs or be in furtherance of CalOptima Health's mission, vision & values, programs, and/or purpose; and

        ii. Inclusion of Details of the Event – Information about the organization and event, including the name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, description of CalOptima Health's Participation in the event, and/or how CalOptima Health's financial Participation will be used, etc.

    d. The CEO or his/her designee is authorized to purchase and use in-kind contributions of items branded with CalOptima Health's logo for the purpose of outreach and promoting CalOptima Health's role and services in the community.

    e. The CEO or his/her designee will report all approved Participation in events involving financial Participation in an amount up to and including twenty-five thousand dollars ($25,000) per organization per fiscal year to the CalOptima Health Board of Directors in the CEO's regular Board communications, including, but not limited to, the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

3. Requests for financial Participation in amounts of more than twenty-five thousand dollars ($25,000) per organization per fiscal year:

    a. Requests for financial Participation for the amount of more than twenty-five thousand dollars ($25,000) per organization per fiscal year shall be submitted no less than sixty (60) calendar days in advance of the date of the event.

    b. Financial requests from qualified external entities for eligible events valued at more than twenty-five thousand dollars ($25,000) require approval from the CalOptima Health Board of Directors and a finding that such financial Participation is in the public good, subject to

availability of budgeted funds, and within CalOptima Health's authority and statutory purpose.

c. All requests for financial Participation to CalOptima Health from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima Health members and/or potential members that could be enrolled in any of CalOptima Health's program, or be in furtherance of CalOptima Health's mission, vision & values, programs, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose, and outcome of the proposed event, description of CalOptima Health's Participation in the event, and/or how CalOptima Health's financial Participation will be used, etc.

d. The CEO or his/her designee is authorized to purchase and use in-kind contributions of items branded with CalOptima Health's logo for the purpose of outreach and promoting CalOptima Health's role and services in the community.

e. The CEO or his/her designee will report all approved Participation in events involving financial Participation in amounts more than twenty-five thousand dollars ($25,000) per organization per fiscal year to the CalOptima Health Board of Directors in the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

4. In determining the value of CalOptima Health's Participation in events involving external entities, the following factors shall be considered:

a. The use of CalOptima Health staff time (*e.g.*, in their capacity as a CalOptima Health employee) to attend events such as health fairs, educational or community events;

b. The use of CalOptima Health resources (*e.g.*, CalOptima Health facilities);

c. The use of current, or future, CalOptima Health eligible funds; and

d. The value of items donated with the CalOptima Health master brand/logo.

H. In no event shall approval of CalOptima Health's Participation in an event, or with an external entity, constitute an Endorsement of the external entity hosting the event, nor shall such Participation constitute Endorsement of any particular message, or initiative, commercial product or service, and/or any message advocated by the external entity. Endorsements and use of CalOptima Health's name, or logo, in any material by an external entity shall be governed by CalOptima Health Policy AA.1214: Guidelines for Endorsements, for Letters of Support, and Use of CalOptima Health's Name and Logo.

I. The CEO or his/her designee shall report any Participation approved by the CEO to the CalOptima Health Board of Directors, in writing, at the next available regularly scheduled Board of Directors meeting after such approval.

J. The CEO or his/her designee shall provide members of the CalOptima Health Board of Directors with advanced notice, so they have the opportunity to attend events in which CalOptima Health participates.

L. Payment for actual and necessary expenses incurred in the course of performing services for CalOptima Health, including expenses incurred in the course of attending functions of external entities, shall be reimbursed, or paid in accordance with CalOptima Health Policy GA.5004: Travel Policy, to the extent there is a clear nexus between the attendance of the employee at such a function and the performance of the service for which such employees is regularly employed. In no event shall CalOptima Health pay or reimburse a CalOptima Health employee for expenses arising from personal expenses, political campaigns or activities, charitable contributions, or events (including fundraisers, galas, dinners, unless expressly approved by the Board of Directors), family expenses, entertainment expenses, or religious activities.

M. In the event CalOptima Health's Participation in an event involving an external entity involves any Marketing Activities, such Marketing Activities shall be consistent with all applicable legal and contractual requirements, as well as all internal policies, including, but not limited to, CalOptima Health Policy MA.2002: Marketing Activity Standards.

III. PROCEDURE

A. All requests for Participation shall be submitted within the timeframe specified above, and include the following information, as appropriate:

1. Description of the external entity requesting Participation, including, but not limited to: whether the external entity is a non-profit organization, religious organization, for-profit organization, or other health care partner (including valid by-laws filed with the Secretary of State of the State of California); how long the external entity has been operating; where the external entity's principle office and base of operations is located; external entity's service area, etc.;

2. Description of the event such as name of the event, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary language of attendees, primary demographics of people served, purpose, and outcome of the proposed event;

3. The purpose of the event, including, but not limited to, a copy of any event materials, or description of the program or project;

4. Description of relationship between external entity's work, or event, and CalOptima Health's programs/lines of business, mission, vision & values, programs, and/or purpose;

5. Description, background, and pertinent information (*e.g.*, names of members of the Board of Directors) regarding the requesting entity and any other entity having a substantial role in the event;

6. A list of other individuals, or entities, supporting the event;

7. Event budget information; and

8. Purpose, role, and anticipated time commitment for CalOptima Health's involvement in the event, if applicable.

B. Upon receipt of a complete request for Participation, CalOptima Health's Community Relations Department shall:

1. Review and analyze the request to ensure each criteria is met;

2. Complete the Event Participation Request Form and place the completed form and all supporting documentation in a folder within five (5) business days of the date of receipt of completed request;

3. Submit the request to the CEO, his/her designee, or to the Board of Directors, where applicable, for consideration. If the request is denied, the requestor shall be notified.

C. Upon receipt of the approved request for Participation from the CEO, his/her designee, or the Board of Directors, CalOptima Health's Community Relations Department shall:

1. Notify the requesting entity of CalOptima Health's determination; and

2. Process the financial request and any necessary documents within three (3) business days of the determination date.

3. Any payments for approved financial requests shall be issued only through checks paid directly to the external entity, and no cash disbursements will be made for events covered by this Policy.

D. Requests for In-Kind Contributions of Items Branded with the CalOptima Health Logo:

1. Requests shall be submitted to CalOptima Health's Community Relations Department, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CalOptima Health master logo.

2. Upon receipt of a complete request to distribute items branded with the CalOptima Health master logo, CalOptima Health's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.

3. The Community Relations Department shall submit a request to the Chief Executive Officer (CEO) or his/her designee for approval of a donation of items valued at five dollars ($5) or less, and up to and including a cumulative total of five hundred dollars ($500) worth of goods. Requests to distribute items that exceed a cumulative total of five hundred dollars ($500) shall require the prior approval of the CalOptima Health Board of Directors.

5. The Community Relations Department shall notify the requesting entity, in writing, after CalOptima Health's determination is made.

6. The Community Relations Department shall process an approved request to distribute items branded with the CalOptima Health master logo within three (3) business days of approval.

7. The requesting entity shall agree to return any items that it does not distribute at the conclusion of the event for which the item was used.

IV. ATTACHMENT(S)

A. CalOptima Health Public Activity Participation Request Form
B. CalOptima Health Public Activity Transmittal Form

V. REFERENCE(S)

A. California Constitution Article 16, §6
B. California Government Code, §8314
C. CalOptima Health Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for Letters of Support, and Use of CalOptima Health Name or Logo
D. CalOptima Health Policy GA.5004: Travel Policy
E. CalOptima Health Policy MA.2002: Marketing Activity Standards

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/02/2017	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/02/2017	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	11/01/2018	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	02/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	10/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	08/05/2021	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	12/01/2022	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	11/01/2023	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	12/01/2024	AA.1223	Participation in Community Events by External Entities	Administrative

IX. GLOSSARY

Term	Definition
Endorsement	For purposes of this policy, the support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima Health does not receive a comparable benefit. Endorsement does not include any sponsored educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
Marketing Activities	For purposes of this policy, any activity conducted by or on behalf of CalOptima Health where information regarding the services offered by CalOptima Health is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and Participation. Marketing also includes any similar activity to secure the Endorsement of any individual or organization on behalf of CalOptima Health.
Participate/ Participation	For purposes of this policy, this is the provision of financial assistance or in-kind contribution of goods, supplies, materials, facilities, staff time, and/or services by CalOptima Health to an external entity in support of one or more events, programs, projects, and/or activities (collectively, "events") in furtherance of CalOptima Health's mission, vision & values, programs, and/or purpose.

Attachment to March 6, 2025 Board of Directors Meeting – Agenda Item 13

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
California School-Based Health Alliance	1203 Preservation Park Way, Suite 302	Oakland	CA	94612

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 20, 2021
Special Meeting of the CalOptima Board of Directors

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

Contacts
Emily Fonda, MD, MMM, CHCQM, Chief Medical Officer, (714) 246-8887
Natalie Zavala, Interim Director, Behavioral Health Integration, (657) 900-1339

Recommended Action
Authorize the Chief Executive Officer to send a Letter of Intent (LOI) by January 31, 2022, to notify the California Department of Health Care Services (DHCS) of CalOptima's intent to participate in the three -year Student Behavioral Health Incentive Program (SBHIP).

Background/Discussion
The Fiscal Year 2021–22 Enacted State Budget includes $4.4 billion dollars to support Children and Youth Behavioral Health Initiative (CYBHI) investments over a five-year period with the aim to improve the behavioral health system for youth (ages 0 to 25). One component of the CYBHI is the SBHIP, through which DHCS will allocate $400 million dollars of incentive payments to Medi-Cal managed care plans (MCPs) statewide. As defined in Assembly Bill (AB) 133, the intent is to establish and build infrastructure, partnerships and capacity for school-based behavioral health services in collaboration with Local Education Agencies (LEAs) and County Mental Health Plans. Incentive payments are not intended to pay for behavioral health treatment services but rather to increase access to services and the number of children receiving services. The current behavioral health Medi-Cal delivery system already allows for reimbursement of such services.

The State recognizes the behavioral health crisis our youth are facing across the nation. Mental health hospitalizations, suicide rates and overdose deaths have increased in our youth over the past decade. The public health emergency stay-at-home orders and school closures have caused further impact. Youth and adolescents have suffered from isolation and chronic stress which are correlated with higher rates of mental illness and substance use disorders. Schools are considered critical points of access for prevention and early intervention services and provide an opportunity to address disparities. This program aims to address potential gaps in access and increase the number of youth receiving behavioral health services.

In order to participate in the SBHIP, CalOptima is required to notify DHCS of its intent to participate in the program no later than January 31, 2022. As such, staff is seeking authorization for the CEO to submit an LOI to DHCS. The provisions of AB 133 related to the Medi-Cal MCP incentive payments are attached. As additional details from DHCS on participation and implementation become available, staff will provide them to the Board and shall return to the Board for further action as necessary, such as amendment to the State Contract to include the incentive program.

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Fiscal Impact

The recommended action to provide DHCS with a commitment letter has no fiscal impact. Staff anticipates funding for the new SBHIP program will be sufficient to fully cover the expenses associated with the additional behavioral health interventions. CalOptima will monitor utilization and expenses closely to ensure SBHIP funding is sufficient to support this new program.

Rationale for Recommendation

Providing the recommended LOI notifies DHCS of CalOptima's intent to participate in the SBHIP.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. AB 133 (Committee on Budget) Student Behavioral Health Incentive Program Provisions

/s/ Michael Hunn *12/15/2021*
Authorized Signature **Date**

AB 133 (Committee on Budget) Student Behavioral Health Incentive Program Provisions

5961.3.

(a) As a component of the initiative, the State Department of Health Care Services shall make incentive payments to qualifying Medi-Cal managed care plans that meet predefined goals and metrics developed pursuant to subdivision (b) associated with targeted interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for K-12 children in schools.

(b) The department, in consultation with the State Department of Education, Medi-Cal managed care plans, county behavioral health departments, local educational agencies, and other affected stakeholders, shall develop the interventions, goals, and metrics used to determine a Medi-Cal managed care plan's eligibility to receive the incentive payments described in this section. Higher incentive payments may be made for activities that increase Medi-Cal reimbursable services provided to children and youth, to reduce health equity gaps, and for services provided to children and youth living in transition, are homeless, or are involved in the child welfare system. Interventions, goals, and metrics include, but are not limited to, the following:

(1) Local planning efforts to review existing plans and documents that articulate children and youth needs in the area; compile data; map existing behavioral health providers and resources; identify gaps, disparities, and inequities; and convene stakeholders and develop a framework for a robust and coordinated system of social, emotional, and behavioral health supports for children and youth.

(2) Providing technical assistance to increase coordination and partnerships between schools and health care plans to build an integrated continuum of behavioral health services using contracts, a memorandum of understanding, or other agreements.

(3) Developing or piloting behavioral health wellness programs to expand greater prevention and early intervention practices in school settings, such as Mental Health First Aid and Social and Emotional Learning.

(4) Expanding the workforce by using community health workers or peers to expand the surveillance and early intervention of behavioral health issues in school-age children 0 to 25 years of age, inclusive.

(5) Increasing telehealth in schools and ensure students have access to technological equipment.

(6) Implementing school-based suicide prevention strategies.

(7) Improving performance and outcomes-based accountability for behavioral health access and quality measures through local student behavioral health dashboards or public reporting.

(8) Increasing access to substance use disorder prevention, early intervention, and treatment.

(c) (1) For each Medi-Cal managed care rating period, as defined in paragraph (3) of subdivision (a) of Section 14105.945, that the department implements this section, the department shall determine the amount of incentive payment earned by each qualifying Medi-Cal managed care plan.

(2) Any incentive payments that are eligible for federal financial participation pursuant to subdivision (e) shall be made in accordance with the requirements for incentive arrangements in Section 438.6(b)(2) of Title 42 of the Code of Federal Regulations and any associated federal guidance.

(d) Incentive payments made pursuant to this section shall be used to supplement and not supplant existing payments to Medi-Cal managed care plans. In addition to developing new collaborative initiatives, incentive payments shall be used to build on existing school-based partnerships between schools and applicable Medi-Cal plans, including Medi-Cal behavioral health delivery systems.

(e) The department shall seek any necessary federal approvals to claim federal financial participation for the incentive payments to qualifying Medi-Cal managed care plans described in this section. If federal approval is obtained for one or more Medi-Cal managed care rating periods, the department shall implement this section only to the extent that federal financial participation is available in that applicable rating period. If federal approval is not obtained for one or more Medi-Cal managed care rating periods, the department may make incentive payments to qualifying Medi-Cal managed care plans as described in this section on a state-only funding basis during the applicable rating period, but only to the extent sufficient funds are appropriated to the department for this purpose and the department determines that federal financial participation for the Medi-Cal program is not otherwise jeopardized as a result.

(f) (1) The department may modify any requirement specified in this section to the extent that it deems the modification necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure that federal financial participation is available or not otherwise jeopardized. The department shall not propose any modification pursuant to this subdivision until the Department of Finance has reviewed and approved a fiscal impact statement.

(2) If the department, after consulting with the State Department of Education, Medi-Cal managed care plans, county behavioral health departments, local educational agencies, and other affected stakeholder entities, determines that the potential modification would be consistent with the goals of this section, the modification may be made in consultation with the Department of Finance and the department shall execute a declaration stating that this determination has been made. The department shall post the declaration on its internet website.

(3) The department shall notify entities consulted in paragraph (2), the Joint Legislative Budget Committee, the Senate Committees on Appropriations, Budget and Fiscal Review, and Health, and the Assembly Committees on Appropriations, Budget, and Health, within 10 business days of that modification or adjustment.

(4) The department shall work with the affected entities and the Legislature to make the necessary statutory changes.

(g) For purposes of this section, the following definitions apply:

(1) "Comprehensive risk contract" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(2) "Local educational agency" means a school district, county office of education, charter school, the California Schools for the Deaf, and the California School for the Blind.

(3) "Medi-Cal managed care plan" means an individual, organization, or entity that enters into a comprehensive risk contract with the department to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to any provision of Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9.

(4) "Medi-Cal behavioral health delivery system" has the meaning described in subdivision (i) of Section 14184.101.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
10. Approve Action Related to the Student Behavioral Health Incentive Program

Contact
Carmen Katsarov LPCC, CCM, Executive Director, Behavioral Health Integration, (714) 796-6168

Recommended Actions
1. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute Memorandums of Understanding (MOUs) and contracts with School Behavioral Health Incentive Program (SBHIP) grantee(s) upon selection and approval by the Department of Health Care Services (DHCS).

Background
The fiscal year 2021–22 enacted state budget includes $4.4 billion dollars to support Children and Youth Behavioral Health Initiative (CYBHI) investments over a five-year period with the aim of improving the behavioral health system for youth (ages 0 to 25).

One component of the CYBHI is the School Behavioral Health Incentive Program (SBHIP) through which DHCS will allocate $400 million dollars of incentive payments to Medi-Cal managed care plans (MCPs) statewide.

The intent of SBHIP is to establish and build infrastructure, partnerships, and capacity for school-based behavioral health services in collaboration with Local Education Agencies (LEAs) and County Mental Health Plans. Please refer to Attachment 1 for additional information that was presented to the Board in December 2021.

Updates

- On March 15, 2022, CalOptima submitted to DHCS the SBHIP partners form with the Orange County Department of Education (OCDE) superintendent, Dr. Al Mijares, identifying the three school districts (Santa Ana Unified, Garden Grove Unified, and Anaheim Unified) that initially confirmed interest in participating in SBHIP.
- CalOptima collaborated with Orange County Health Care Agency (OC HCA) for increased collaboration with Orange County superintendents for SBHIP. CalOptima's Executive Director, Behavioral Health Integration, is now attending the weekly superintendent mental health work group. This increased collaboration effort resulted in 17 school districts confirming interest in participating in SBHIP as of June 2022. *See* Attachment 2.
- CalOptima received 50% of the allotted needs assessment funds in the amount of $217,500 from DHCS on June 14, 2022.

Discussion
CalOptima is currently working on the DHCS deliverables below with OCDE, LEAs' school superintendents, and OC HCA. The MOU is an important part of the implementation plan for SBHIP. *See* Attachment 3.

DHCS SBHIP Timeline and Deliverables	DHCS Due Date	Status/ Start Date
Board Approval for Letter of Intent (LOI)	12/20/21	Completed
Submit LOI to DHCS	1/31/22	Completed
Partners Form Due to DHCS (Milestone One)	3/15/22	Completed
Medi-Cal MCPs and selected partners conduct assessment	2nd/3rd Quarter 2022	In Progress
Select targeted intervention(s) and submit project plan (Milestone One) to DHCS	12/31/22	August 2022

Once CalOptima collects more data and receives additional guidance from DHCS, staff will return to the Board with a plan for distributing funds to the school districts.

Fiscal Impact
Staff anticipates funding for the new SBHIP program to be sufficient to fully cover expenses associated with the additional behavioral health interventions. CalOptima will monitor utilization and expenses closely to ensure SBHIP funding is sufficient to support this new program.

Rationale for Recommendation
Staff recommends that the Board approve the recommended action so CalOptima can continue to meet all regulatory timelines and DHCS deliverables related to SBHIP. Participation in SBHIP will contribute toward CalOptima's overall goal, in partnership with the OC HCA, of creating a comprehensive and sustainable continuous system of care for all students to access the entire scope of available mental health benefits and services in Orange County.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. December 15, 2021, previous COBAR for approval of LOI with AB 133 (Committee on Budget) Student Behavioral Health Incentive Program Provisions
2. List of participating LEAs
3. SBHIP MOU Template Draft

Board Action

Board Meeting Dates	Action	Term	Not to Exceed Amount
12/20/2021	Approved	N/A	N/A

/s/ Michael Hunn *07/28/2022*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 20, 2021
Special Meeting of the CalOptima Board of Directors

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

Contacts
Emily Fonda, MD, MMM, CHCQM, Chief Medical Officer, (714) 246-8887
Natalie Zavala, Interim Director, Behavioral Health Integration, (657) 900-1339

Recommended Action
Authorize the Chief Executive Officer to send a Letter of Intent (LOI) by January 31, 2022, to notify the California Department of Health Care Services (DHCS) of CalOptima's intent to participate in the three -year Student Behavioral Health Incentive Program (SBHIP).

Background/Discussion
The Fiscal Year 2021–22 Enacted State Budget includes $4.4 billion dollars to support Children and Youth Behavioral Health Initiative (CYBHI) investments over a five-year period with the aim to improve the behavioral health system for youth (ages 0 to 25). One component of the CYBHI is the SBHIP, through which DHCS will allocate $400 million dollars of incentive payments to Medi-Cal managed care plans (MCPs) statewide. As defined in Assembly Bill (AB) 133, the intent is to establish and build infrastructure, partnerships and capacity for school-based behavioral health services in collaboration with Local Education Agencies (LEAs) and County Mental Health Plans. Incentive payments are not intended to pay for behavioral health treatment services but rather to increase access to services and the number of children receiving services. The current behavioral health Medi-Cal delivery system already allows for reimbursement of such services.

The State recognizes the behavioral health crisis our youth are facing across the nation. Mental health hospitalizations, suicide rates and overdose deaths have increased in our youth over the past decade. The public health emergency stay-at-home orders and school closures have caused further impact. Youth and adolescents have suffered from isolation and chronic stress which are correlated with higher rates of mental illness and substance use disorders. Schools are considered critical points of access for prevention and early intervention services and provide an opportunity to address disparities. This program aims to address potential gaps in access and increase the number of youth receiving behavioral health services.

In order to participate in the SBHIP, CalOptima is required to notify DHCS of its intent to participate in the program no later than January 31, 2022. As such, staff is seeking authorization for the CEO to submit an LOI to DHCS. The provisions of AB 133 related to the Medi-Cal MCP incentive payments are attached. As additional details from DHCS on participation and implementation become available, staff will provide them to the Board and shall return to the Board for further action as necessary, such as amendment to the State Contract to include the incentive program.

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Fiscal Impact
The recommended action to provide DHCS with a commitment letter has no fiscal impact. Staff anticipates funding for the new SBHIP program will be sufficient to fully cover the expenses associated with the additional behavioral health interventions. CalOptima will monitor utilization and expenses closely to ensure SBHIP funding is sufficient to support this new program.

Rationale for Recommendation
Providing the recommended LOI notifies DHCS of CalOptima's intent to participate in the SBHIP.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. AB 133 (Committee on Budget) Student Behavioral Health Incentive Program Provisions

/s/ Michael Hunn *12/15/2021*
Authorized Signature **Date**

AB 133 (Committee on Budget) Student Behavioral Health Incentive Program Provisions

5961.3.

(a) As a component of the initiative, the State Department of Health Care Services shall make incentive payments to qualifying Medi-Cal managed care plans that meet predefined goals and metrics developed pursuant to subdivision (b) associated with targeted interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for K-12 children in schools.

(b) The department, in consultation with the State Department of Education, Medi-Cal managed care plans, county behavioral health departments, local educational agencies, and other affected stakeholders, shall develop the interventions, goals, and metrics used to determine a Medi-Cal managed care plan's eligibility to receive the incentive payments described in this section. Higher incentive payments may be made for activities that increase Medi-Cal reimbursable services provided to children and youth, to reduce health equity gaps, and for services provided to children and youth living in transition, are homeless, or are involved in the child welfare system. Interventions, goals, and metrics include, but are not limited to, the following:

(1) Local planning efforts to review existing plans and documents that articulate children and youth needs in the area; compile data; map existing behavioral health providers and resources; identify gaps, disparities, and inequities; and convene stakeholders and develop a framework for a robust and coordinated system of social, emotional, and behavioral health supports for children and youth.

(2) Providing technical assistance to increase coordination and partnerships between schools and health care plans to build an integrated continuum of behavioral health services using contracts, a memorandum of understanding, or other agreements.

(3) Developing or piloting behavioral health wellness programs to expand greater prevention and early intervention practices in school settings, such as Mental Health First Aid and Social and Emotional Learning.

(4) Expanding the workforce by using community health workers or peers to expand the surveillance and early intervention of behavioral health issues in school-age children 0 to 25 years of age, inclusive.

(5) Increasing telehealth in schools and ensure students have access to technological equipment.

(6) Implementing school-based suicide prevention strategies.

(7) Improving performance and outcomes-based accountability for behavioral health access and quality measures through local student behavioral health dashboards or public reporting.

(8) Increasing access to substance use disorder prevention, early intervention, and treatment.

(c) (1) For each Medi-Cal managed care rating period, as defined in paragraph (3) of subdivision (a) of Section 14105.945, that the department implements this section, the department shall determine the amount of incentive payment earned by each qualifying Medi-Cal managed care plan.

(2) Any incentive payments that are eligible for federal financial participation pursuant to subdivision (e) shall be made in accordance with the requirements for incentive arrangements in Section 438.6(b)(2) of Title 42 of the Code of Federal Regulations and any associated federal guidance.

(d) Incentive payments made pursuant to this section shall be used to supplement and not supplant existing payments to Medi-Cal managed care plans. In addition to developing new collaborative initiatives, incentive payments shall be used to build on existing school-based partnerships between schools and applicable Medi-Cal plans, including Medi-Cal behavioral health delivery systems.

(e) The department shall seek any necessary federal approvals to claim federal financial participation for the incentive payments to qualifying Medi-Cal managed care plans described in this section. If federal approval is obtained for one or more Medi-Cal managed care rating periods, the department shall implement this section only to the extent that federal financial participation is available in that applicable rating period. If federal approval is not obtained for one or more Medi-Cal managed care rating periods, the department may make incentive payments to qualifying Medi-Cal managed care plans as described in this section on a state-only funding basis during the applicable rating period, but only to the extent sufficient funds are appropriated to the department for this purpose and the department determines that federal financial participation for the Medi-Cal program is not otherwise jeopardized as a result.

(f) (1) The department may modify any requirement specified in this section to the extent that it deems the modification necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure that federal financial participation is available or not otherwise jeopardized. The department shall not propose any modification pursuant to this subdivision until the Department of Finance has reviewed and approved a fiscal impact statement.

(2) If the department, after consulting with the State Department of Education, Medi-Cal managed care plans, county behavioral health departments, local educational agencies, and other affected stakeholder entities, determines that the potential modification would be consistent with the goals of this section, the modification may be made in consultation with the Department of Finance and the department shall execute a declaration stating that this determination has been made. The department shall post the declaration on its internet website.

(3) The department shall notify entities consulted in paragraph (2), the Joint Legislative Budget Committee, the Senate Committees on Appropriations, Budget and Fiscal Review, and Health, and the Assembly Committees on Appropriations, Budget, and Health, within 10 business days of that modification or adjustment.

(4) The department shall work with the affected entities and the Legislature to make the necessary statutory changes.

(g) For purposes of this section, the following definitions apply:

(1) "Comprehensive risk contract" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(2) "Local educational agency" means a school district, county office of education, charter school, the California Schools for the Deaf, and the California School for the Blind.

(3) "Medi-Cal managed care plan" means an individual, organization, or entity that enters into a comprehensive risk contract with the department to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to any provision of Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9.

(4) "Medi-Cal behavioral health delivery system" has the meaning described in subdivision (i) of Section 14184.101.

K-12 School Districts	Partner with CalOptima for SBHIP	School Contact
1. Anaheim Elementary	Yes	Shirley Diaz
2. Anaheim Union High	Yes	Dr. Adela Cruz, LCSW
3. Brea Olinda Unified	Yes	Cherry Lee, NCSP. BCBA
4. Buena Park	Yes	Elsie Briseño Simonovski, Ph.D
5. Centralia Elementary	Yes	Michelle Castillo/ Stacy Chang
6. Cypress	Yes	Tandy Taylor
7. Fullerton Joint Union High	Yes	Carlos Alcántara, LCSW, PPSC
8. Garden Grove Unified	Yes	Jeffrey Layland, Ed.D.
9. Huntington Beach City	Yes	Megan Kempner
10. Laguna Beach Unified	Yes	Michael Keller
11. Los Alamitos Unified	Yes	Grace Delk
12. Lowell Joint	Yes	Sheri McDonald, Ed.D.
13. Magnolia	Yes	Wendy Castillo
14. Orange Unified	Yes	Kristen Nelson, M.A.
15. Santa Ana Unified	Yes	Sonia Llamas, Ed.D
16. Savanna	Yes	Hipolito Murillo
17. Tustin Unified	Yes	Monique Yessian

MEMORANDUM OF UNDERSTANDING
BETWEEN

_____

AND
ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA
FOR STUDENT BEHAVIORAL HEALTH INCENTIVE PROGRAM

This Memorandum of Understanding ("**MOU**") is made and entered into as of this ___ day of ____, 2023 ("**Effective Date**"), by and between [insert legal name here] ("**School District**") and Orange County Health Authority dba CalOptima ("**CalOptima**") in order to facilitate successful implementation of School District's Student Behavioral Health Incentive Program ("**SBHIP**"). School District and CalOptima may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. In accordance with California Welfare & Institutions Code Section 5961.3, the California Department of Health Care Services ("DHCS") designed and implemented the SBHIP to increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for K-12 children in public schools;

B. DHCS established a process, in partnership with Medi-Cal managed care plans ("MCPs") and eligible Orange County school districts, for MCPs to oversee and administer payment for approved SBHIP intervention implementation plan(s);

C. CalOptima, as an MCP participating in the SBHIP, has selected School District's intervention implementation plan(s) ("**Plan**") for the SBHIP; and

D. CalOptima is responsible for oversight and administration of payments to School District consistent with the terms of the SBHIP, the Plan, any terms imposed as a condition of federal approval of the SBHIP, and any DHCS guidance related to the SBHIP.

AGREEMENT

Therefore, CalOptima and School District agree as follows:

1. **Term**. The Term of this MOU shall begin on the Effective Date and shall terminate on [insert termination date], unless earlier terminated under Section 2.

2. **Termination**. The terms of this MOU are contingent upon the approval of School District's SBHIP intervention implementation plan(s), the availability of sufficient state and federal Medicaid funding, and all necessary federal approvals to be obtained by DHCS. Should sufficient funds not be allocated, federal financial participation be unavailable, or DHCS not obtain the necessary approvals, CalOptima may modify the services under the MOU accordingly upon written notice to School District or terminate this MOU after giving School District thirty (30) days' prior written notice. CalOptima

may also terminate this MOU with thirty (30) days' prior written notice to School District and DHCS if School District (i) breaches a material term of the MOU and fails to correct the breach within the thirty (30)-day notice period, or (ii) fails to meet terms of a corrective action plan ("**CAP**"), as set forth in Section 5.

3. **Scope of Project.** School District is responsible for the implementation of and compliance with the SBHIP, as set forth in Plan, which is attached to this MOU as Exhibit 1 and incorporated into the MOU by this reference. School District's compliance includes reporting to CalOptima on the achievement of milestones and objectives consistent with the terms of the SBHIP and the Plan. School District shall promptly notify CalOptima of any material change in information submitted in support of the SBHIP or the Plan, including changes in organizational leadership, business operations, and financial standing. CalOptima is responsible for overseeing the SBHIP as it relates to School District, including monitoring and verifying milestone achievements and administering payments consistent with the terms of the SBHIP, the Plan, any terms imposed as a condition of federal approval of the SBHIP, and any subsequent DHCS guidance related to the SBHIP.

4. **Confidentiality.** CalOptima and School District's performance under this MOU may require the exchange of confidential and/or proprietary information ("**Confidential Information**") as may be identified by either Party. Confidential Information includes but is not limited to computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements, projections, methodologies, data, reports, agreements, intellectual property, trade secrets, licensing plans, and proprietary or other information, materials, records, writings, or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Each Party agrees to protect the other Party's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care. The Parties also shall comply with the processes, standards, and other requirements applicable to the exchange of either Party's respective Confidential Information, in accordance with applicable state and federal law.

5. **Corrective Action**. Upon written notice to School District, CalOptima may implement a CAP for School District or other DHCS-required mechanism (i) to modify the MOU requirements, (ii) to facilitate School District's compliance with the MOU and SBHIP terms, or (iii) to adjust SBHIP/Plan goals and objectives and related payments, as necessary. Such modifications are subject to DHCS review and approval. School District's noncompliance with modifications under this Section 5 may result in CalOptima's termination of this MOU under Section 2. In the event of MOU termination under Section 2, School District shall return funds distributed to School District under this MOU as directed by CalOptima.

6. **School District Responsibilities**.

   A. Use of Funding.

i. School District shall only expend funds provided to School District by CalOptima under this MOU for the purposes of carrying out activities and achieving milestones set forth in this MOU and the Plan.

ii. School District shall document to CalOptima, in a form and manner determined by CalOptima, that Plan activities have been carried out and milestones have been achieved under this MOU.

iii. If School District does not carry out Plan activities and achieve Plan milestones, School District shall promptly notify CalOptima and return any funds that School District received related to those unperformed activities or unachieved milestones under the Plan.

B. Practice Redesign and Infrastructure Development Reporting.

i. School District shall timely implement the practice redesign and infrastructure development components set forth in and in accordance with the terms of the Plan.

ii. School District shall regularly report to CalOptima on the progress of the practice redesign and infrastructure development on a schedule in a format and process specified in the Plan or as otherwise agreed in writing between the Parties.

C. Milestone Achievement.

i. School District shall perform all tasks necessary to meet milestones required by the Plan. School District shall provide CalOptima with the information necessary for CalOptima to determine School District's progress in achieving the milestones set forth in the Plan.

D. Measure Reporting.

i. School District will report to CalOptima on target population measures on a schedule in a format and process required by SBHIP, the Plan, or as otherwise agreed in writing between the Parties.

ii. School District will regularly report performance measures to CalOptima consistent with the specifications required in the Plan and by the SBHIP.

7. **CalOptima Responsibilities.**

A. Monitoring Project Milestones and Measures. CalOptima will evaluate all information provided by School District related to implementation of the Plan(s) to ensure School District's compliance with the Plan and track School District's goals

and milestones under the Plan.

B. Reporting to DHCS. CalOptima will report to DHCS on the Plan status as specified in the terms of the Plan(s), the terms of federal approval for the SBHIP, and any applicable DHCS-issued guidance.

C. Administration of Project Funds.

i. *Initial Payment*. Within [XX] days of CalOptima's selection and acceptance of the Plan, CalOptima will provide initial payment to School District, as set forth in the terms of the Plan and SBHIP.

ii. *Milestone Payments*. Subsequent to the initial payment, all ongoing payments to School District will be tied to achieving practice redesign components, milestones, or defined progress toward goals required by terms of SBHIP and the Plan. CalOptima will remit milestone payments to School District within [XX] days of School District's successful demonstration to CalOptima of each milestone achievement per the terms of SBHIP and the Plan. CalOptima may adjust milestone measurement and related payments consistent with the terms of a CAP. CalOptima will not make any milestone payments to School District until all of School District's past due reporting is completed to CalOptima's satisfaction.

8. **Liaison.** CalOptima and School District will each designate a liaison(s) to serve as a point of contact for activities performed related to this MOU.

9. **MOU Monitoring.** CalOptima and School District will meet on a mutually agreed upon frequency, or upon request a Party's to monitor the performance of parties' responsibilities related to this MOU.

10. **Dispute Resolution.** If there is a dispute that cannot be resolved by the Parties under Section 9, either Party may submit a request for resolution to DHCS. A Party shall give the other Party five (5) business days' notice of its intent to submit a request for resolution.

11. **Notice and Correspondence.** All notices and correspondence concerning this MOU shall be in writing and sent to:

SCHOOL DISTRICT
Attn:
Address:

CALOPTIMA
Attn:
Address:

12. **No Liability of County of Orange.** As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and School District acknowledge and agree that the obligations of CalOptima under this MOU are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability under this MOU.

13. **Independent Contractor**. The Parties intend to establish an independent contractual relationship under this MOU rather than an employer/employee relationship. School District agrees that neither it nor its employees or agents are employees, agents, or legal representatives of CalOptima for any purpose, and nothing in this MOU shall be construed to create a partnership, joint venture, or employment contract between the Parties.

14. **Amendments**. Except as otherwise provide herein, the Parties may amend this MOU only in writing and signed by both Parties; provided, however, that if any law, rule, or regulation applicable to this MOU, or any interpretation thereof by any court, is modified or implemented during the term of the MOU in a way that materially changes the terms of the MOU ("**Regulatory Change**"), CalOptima may, upon written notice to School District, amend the MOU to the minimum degree necessary to comply with the Regulatory Change.

15. **Assignment**. School District may not assign or delegate any obligations or rights under this MOU without the prior written consent of CalOptima.

16. **Counterparts**. This MOU 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.

17. **Waiver**. Any failure of CalOptima to insist upon strict compliance with any provision of this MOU shall not be deemed a waiver of such provision or any other provision of this MOU. To be effective, a CalOptima waiver must be in a writing that is signed and dated by CalOptima.

18. **Governing Law**. This MOU shall be governed by the laws of the State of California, and the Parties consent to venue and personal jurisdiction over them in Superior Court in Orange, California, and in U.S. District Court for the Central District of California, as applicable, for purposes of construction and enforcement of this MOU.

19. **Authorizations**. Each Party warrants that it has the full right, power, and authority to enter into and fully perform its obligations under this MOU and the execution, delivery, and performance of this MOU by that Party does not conflict with any other agreement to which it is a party or by which it is bound.

20. **Interpretation**. Each Party has had the opportunity to have counsel of its choice examine the provisions of this MOU, and no implication shall be drawn against any Party by virtue of the drafting of this MOU.

21. **Recitals and Exhibits**. The recitals and exhibits set forth in this MOU are made a part of the MOU by this reference.

WHEREFORE, School District and CalOptima have executed the MOU in the County of Orange, California.

School District:

Signature: _____

Name: _____

Title: _____

Date: _____

CalOptima

Signature: _____

Name: _____

Title: _____

Date: _____

EXHIBIT 1
SBHIP Targeted Implementation Plan

[insert Targeted Intervention Implementation Plan Proposal document]

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 4, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
17. Approve Actions Related to the Student Behavioral Health Incentive Program Funding Strategy

Contacts
Carmen Katsarov LPCC, CCM, Executive Director Behavioral Health Integration, (714) 796-6168
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Recommended Actions
1. Authorize CalOptima Health's Chief Executive Officer (CEO) to allocate and distribute Student Behavioral Health Incentive Program (SBHIP) incentive payment funds per the proposed incentive funding plan in an aggregate amount not to exceed $25.5 million;
2. Authorize CalOptima Health's CEO to issue a notice of funding opportunity for grants to serve school-aged children and youth in Orange County; and
3. Authorize funding for and distribution of incentive payment prior to CalOptima Health's receipt of SBHIP program incentive dollars from the State of California.

Background/Discussion
The SBHIP is a Department of Health Care Services (DHCS) 3-year state initiative incentive program from January 1, 2022, to December 31, 2024. The intent of SBHIP is to establish and build infrastructure, partnerships, and capacity for school-based behavioral health services in collaboration with managed care plans, local education agencies (LEAs) and county mental health plans. DHCS determined that CalOptima Health is eligible to receive incentive payments up to $25,459,676.

The Board has approved two actions related to SBHIP. The first action on December 20, 2021, authorized the CEO to send a letter of intent by January 31, 2022, to notify DHCS of CalOptima Health's intent to participate in the 3-year SBHIP. The second action on August 4, 2022~~2023~~, authorized the CEO, with the assistance of legal counsel, to execute memorandums of understanding and contracts with SBHIP grantee(s) upon selection and approval by the DHCS. *Rev. 5/4/2023*

During 2022, as instructed by DHCS, Orange County Department of Education (OCDE) and all 29 Orange County (OC) School Districts as the LEAs and CalOptima Health completed the required needs assessment to identify students' behavioral health needs and service gaps. CalOptima Health was required to select four targeted interventions from DHCS's approved list based on the results of the needs assessment. The LEAs chose Children's Hospital of Orange County (CHOC), Western Youth Services (WYS), and Hazel Health as partners to implement the following four targeted interventions:

1) Behavior Health Screenings and Referrals
2) Building Stronger Partnerships to Increase Access to Medi-Cal Services
3) Technical Assistance Support for Contracts
4) IT Enhancements for Behavioral Services

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On March 8, 2023, DHCS approved CalOptima Health for the four targeted interventions. The eligible funding allocation is as follows:

Allocation Description	Eligible Allocation	Status
Needs Assessment – 50% prior to completion	$217,500	Allocation received on June 14, 2022
Needs Assessment – 50% fully completed	$217,500	Expected to be received by May 2023
Targeted Interventions – 50% of the maximum allocation incentive	$12,512,338	Expected to be received by May 2023
Medi-Cal MCPs submit Bi-Quarterly (6-month) Report due 6/30/2023, 12/31/2023, 6/30/2024	Est. $9,384,253 Up to 75% of the targeted intervention remaining allocation	Expected 10/2023, 4/2024 and 10/2024
Medi-Cal MCPs submit Project Outcomes Report for each targeted intervention due December 31, 2024	Est. $3,128,085 Up to 25% of the targeted intervention remaining allocation	Expected 4/2025
	Total $25,459,676	

CalOptima Health requests Board approval for the proposed SBHIP Incentive Funding Plan for program years 2023-2024.

Entity	Description	Amount	Method
CalOptima Health	Program Support Positions (example: administrative, clinical, contracting)	Up to $200K	N/A
Children's Hospital Orange County (CHOC)	1) Build out of ten (10) new Well Spaces • Staff to provide consultation and supervision to establish the clinical model and coordination of the new Well Spaces. • Staff to provide quality monitoring services of the new Well Spaces. 2) Establish: • Emergency Department/Intensive Care School Transition Coordinator. • Staffing for the Mental Health Crisis Clinic for direct linkage from schools to CHOC for in person or telehealth mental health services. • Mental Health services for deaf and hard of hearing students. • Autism Comprehensive Care Program for students that have comorbid autism spectrum disorder and/or similar neurodevelopmental conditions and acute/severe mental health concerns (e.g., depression, suicidal ideation/behaviors, anxiety, etc.) between the ages of 12 and 17.	Up to $2.1M	Contract

Western Youth Services (WYS)	1) Develop a Behavioral Health Curriculum tailored for OC LEAs. 2) Train LEAs on core clinical competencies, including screening tools, adverse childhood experiences and prevention, and early intervention strategies to address behavioral health issues in the school setting. 3) Consultative support services post-training.	Up to $802K	Contract
Hazel Health	Implement a behavioral health telehealth platform for all 29 school districts that all 442K students (uninsured, Medi-Cal, and private) can access to receive behavioral health telehealth counseling services. This includes: 1) The technology infrastructure and equipment. 2) Dedicated implementation team for schools, which includes: • Initial and ongoing implementation and training. • Communication and marketing material and support. • Community engagement team. • Outcome reporting (utilization, time to care, number of community referrals). 3) Coordination of care for all students that use the telehealth service. Ex: linkage to county and or long-term services or supports. **Note:** Hazel Health is contracted with many private insurers and will contract with CalOptima Health. Hazel Health will bill the appropriate insurer for allowable behavioral health services separately from SBHIP funds for the behavioral health telehealth platform.	Up to $8.4M	Contract
Grants For Organizations Serving Medi-Cal School-Aged Children and Youth in Orange County	To apply for the grant, organizations may fall under the following categories: 1) Needs assistance to create or expand behavioral health services for special populations, for example: foster youth, students with developmental disabilities. 2) Needs infrastructure or capacity building assistance. 3) Needs assistance to create an innovative behavioral health program serving school-aged children and youth for services not covered under Medi-Cal.	Up to $3.5M	Notice of Funding Opportunity
All 29 Orange County LEA/School Districts	1) Hiring additional behavioral health clinical staff (e.g. social worker, school counselors, school psychologists), and administrative staff. 2) Training and material development. 3) Implementation of a secure, HIPAA-compliant electronic health record (EHR). 4) Billing systems enhancements and/or billing administrator.	Up to $10.0M	Contract
Remaining Unallocated Budget		Up to $471K	
Total		$25.5M	

Staff will return to the Board at a future meeting with recommendations on the remaining unallocated and unused SBHIP budget or in the event there are adjustments to the forecasted SBHIP funding levels from DHCS.

Monitoring and Oversight

The State requires specific SBHIP performance requirements to be reported by CalOptima Health every six months on the approved project plans. CalOptima Health's Behavioral Health Integration (BHI) department created a tool to track the performance requirements and activities identified for each of the four targeted interventions. CalOptima Health will require the SBHIP partners (LEAs, CHOC, WYS, Hazel Health) and grantees to meet all contractual and grant provisions to ensure performance of targeted interventions and comply with reporting requirements. Partners and grantees will be required to submit timely and accurate reports on a quarterly basis on the targeted intervention measures.

Fiscal Impact

The aggregate amount payable is not anticipated to exceed $25.5 million, the estimated maximum earnable amount of incentive payments DHCS has allocated to CalOptima Health. If CalOptima Health is able to earn the maximum amount, the fiscal impact of the three (3)-year SBHIP is projected to be budget neutral.

CalOptima Health reserves the right to adjust funding from partners and grantees in the event funding from DHCS is insufficient to support the proposed funding plan or to recoup funds for lack of demonstrating effort and performance against targeted intervention measures.

Rationale for Recommendation

CalOptima Health recommends proceeding with the requested actions in order for the SBHIP activities to continue. CalOptima Health BHI leadership will bring additional funding recommendations and/or updates to the Board.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. LEA TI Tracker - Example

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
12/20/2021	Approved	N/A	N/A
8/4/2022	Approved	N/A	N/A

/s/ Michael Hunn *04/26/2023*
Authorized Signature **Date**

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Exhibit - LEA TI Tracker - Example

LEAs/Partners Targeted Intervention Implementation Progress:	Entity / LEA:
1) Describe, clearly and in detail, for each selected LEA, the progress made towards implementing the selected intervention during this bi-quarterly segment. Provide documentation evidencing the level of progress reported.	
2) Identify the current status of the SBHIP targeted intervention: (On Track / Not On Track)	
3) If the project is Not On Track, has SBHIP Technical Assistance been contacted? (Yes / No)	
4) If the SBHIP targeted intervention is not on track, explain, clearly and in detail, why and identify what actions will be taken to remedy the current course. If the project is on track, write N/A.	
5) Have there been any changes in SBHIP partners based on the Project Plan submission? (Yes / No)	
6) If changes have been made, describe clearly and in detail, why.	
7) Have there been any changes to the student population initially identified as recipients of the selected intervention? (Yes / No)	
8) If changes have been made, describe clearly and in detail, why.	
9) 7 - Please identify, clearly and in detail, any current internal SBHIP challenges experienced in connection with this project at this point.	
10) Please identify, clearly and in detail, any current external SBHIP challenges experienced in connection with this project at this point.	

TI Significant Project Markers/Task	Entity or LEA
BH Screening and Referrals	
Discovery Phase:	
Jan-Jun 2023	
Conduct School Infrastructure Assessment	
Research Screener Tool Options	
Jul-Dec 2023	
Identify Intervention Budget Allocation	
Planning/Design Phase:	
Jul-Dec 2023	
Identify Business/Technical Requirements	
Develop Scope of Work	
Select Appropriate Universal Validated Screener Tools	
Jan-Jun 2024	
Identify Technical Requirements	
Develop Individual LEA Implementation plans	

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Financial Summary

April 30, 2025

Board of Directors Meeting

June 5, 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: April 2025

April 2025 Actual	April 2025 Budget	April 2025 $ Variance	April 2025 % Variance		July 2024 - April 2025 Actual	July 2024 - April 2025 Budget	July 2024 - April 2025 $ Variance	July 2024 - April 2025 % Variance
901,899	901,997	(98)	(0.0%)	Member Months	9,115,951	9,008,279	107,672	1.2%
392,520,755	359,983,298	32,537,457	9.0%	Revenues	4,260,164,958	3,572,238,549	687,926,409	19.3%
365,105,164	351,028,604	(14,076,560)	(4.0%)	Medical Expenses	3,931,330,778	3,545,190,357	(386,140,421)	(10.9%)
22,147,646	25,685,364	3,537,718	13.8%	Administrative Expenses	209,524,864	247,189,069	37,664,205	15.2%
5,267,946	**(16,730,670)**	**21,998,616**	**131.5%**	**Operating Margin**	**119,309,315**	**(220,140,877)**	**339,450,192**	**154.2%**
				Non-Operating Income (Loss)				
19,743,475	6,666,660	13,076,815	196.2%	Net Investment Income/Expense	169,331,253	66,666,600	102,664,653	154.0%
(13,813)	(117,280)	103,467	88.2%	Net Rental Income/Expense	(377,142)	(1,172,800)	795,658	67.8%
5,594,045	-	5,594,045	100.0%	Net MCO Tax	5,584,111	-	5,584,111	100.0%
(27,515)	(1,178,825)	1,151,310	97.7%	Grant Expense	(14,228,947)	(11,697,341)	(2,531,606)	(21.6%)
(22,386)	-	(22,386)	(100.0%)	Other Income/Expense	2,209	-	2,209	100.0%
25,273,805	**5,370,555**	**19,903,250**	**370.6%**	**Total Non-Operating Income (Loss)**	**160,311,484**	**53,796,459**	**106,515,025**	**198.0%**
30,541,751	**(11,360,115)**	**41,901,866**	**368.9%**	**Change in Net Assets**	**279,620,799**	**(166,344,418)**	**445,965,217**	**268.1%**
93.0%	*97.5%*	*(4.5%)*		*Medical Loss Ratio*	*92.3%*	*99.2%*	*(7.0%)*	
5.6%	*7.1%*	*1.5%*		*Administrative Loss Ratio*	*4.9%*	*6.9%*	*2.0%*	
1.3%	*(4.6%)*	*6.0%*		*Operating Margin Ratio*	*2.8%*	*(6.2%)*	*9.0%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
87.3%	*92.7%*	*(5.3%)*		**Adjusted MLR*	*86.0%*	*94.3%*	*(8.4%)*	
5.6%	*7.1%*	*1.5%*		**Adjusted ALR*	*5.4%*	*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.

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Financial Highlights Notes: April 2025

- Notable events/items in April 2025
  - $106.6 million of receipts for the Hospital Quality Assurance Fee (HQAF) program received and paid in May 2025. This is a pass-through item with no impact to CalOptima Health's Change in Net Assets.
  - $5.6 million net non-operating income from Calendar Year (CY) 2024 Managed Care Organization (MCO) tax.
  - Favorable revenue due primarily to:
    - The revised CY 2025 draft rates received in December were favorable compared to budget assumptions. Staff anticipates additional rate amendments are forthcoming from the Department of Health Care Services (DHCS) due to program and member acuity changes.

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FY 2024-25: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) April 2025: $30.5 million, favorable to budget $41.9 million or 368.9% primarily due to:
    - Favorable net investment income, enrollment and CY 2025 premium capitation rates
  - Year To Date (YTD) July 2024 – April 2025: $279.6 million, favorable to budget $446.0 million or 268.1% primarily due to:
    - Favorable net investment income, premium capitation rates and enrollment in the Medi-Cal (MC) Line of Business (LOB)

FY 2024-25: Management Summary (cont.)

- Enrollment
  - MTD: 901,899 members, unfavorable to budget 98
  - YTD: 9,115,951 member months, favorable to budget 107,672 or 1.2%

- Revenue
  - MTD: $392.5 million, favorable to budget $32.5 million or 9.0% driven by MC LOB due to CY 2024 and 2025 Quality Withhold and Incentive (QWI) program accrual, favorable enrollment, and CY 2025 premium capitation rates
  - YTD: $4,260.2 million, favorable to budget $687.9 million or 19.3% driven by MC LOB due to CY 2022 and 2023 Hospital Directed Payments (DP), favorable enrollment and premium capitation rates

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FY 2024-25: Management Summary (cont.)

- Medical Expenses
  - MTD: $365.1 million, unfavorable to budget $14.1 million or 4.0% driven by:
    - $8.5 million in MC Professional Claims expenses due to an increase in utilization in Physician Services and Mental Health
    - $4.6 million in MC Other Medical Expenses primarily due to CY 2025 Community Reinvestment and Quality Achievement accruals
    - $2.9 million in OneCare (OC) Prescription Drug expenses

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FY 2024-25: Management Summary (cont.)

- Medical Expenses (cont.)
  - YTD: $3,931.3 million, unfavorable to budget $386.1 million or 10.9% driven by:
    - $421.5 million in MC Other Medical Expenses due primarily to CY 2022 and 2023 Hospital DP, and CY 2025 Community Reinvestment and Quality Achievement
    - Offset by $14.0 million in MC Incentive Payments expenses due to Hospital Quality Program (HQP)

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FY 2024-25: Management Summary (cont.)

- Administrative Expenses
  - MTD: $22.1 million, favorable to budget $3.5 million or 13.8%
  - YTD: $209.5 million, favorable to budget $37.7 million or 15.2%

- Non-Operating Income (Loss)
  - MTD: $25.3 million, favorable to budget $19.9 million or 370.6% primarily due to favorable Net Investment Income of $13.1 million and favorable Net Managed Care Organization (MCO) Tax of $5.6 million
  - YTD: $160.3 million, favorable to budget $106.5 million or 198.0% primarily due to favorable Net Investment Income of $102.7 million and favorable Net MCO Tax of $5.6 million

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FY 2024-25: Key Financial Ratios

- Medical Loss Ratio (MLR)

		Actual	Budget	Variance (%)
MTD	MLR	93.0%	97.5%	(4.5%)
	Adjusted MLR*	87.3%	92.7%	(5.3%)
YTD	MLR	92.3%	99.2%	(7.0%)
	Adjusted MLR*	86.0%	94.3%	(8.4%)

- Administrative Loss Ratio (ALR)

		Actual	Budget	Variance (%)
MTD	ALR	5.6%	7.1%	1.5%
	Adjusted ALR*	5.6%	7.1%	1.5%
YTD	ALR	4.9%	6.9%	2.0%
	Adjusted ALR*	5.4%	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.

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CalOptima Health

FY 2024-25: Key Financial Ratios (cont.)

- Balance Sheet Ratios
  - Current ratio*: 1.7
  - Board Designated Reserve level: 3.86
  - Statutory Designated Reserve level: 1.03
  - Net-position: $2.7 billion, including required TNE of $128.1 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations.

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Enrollment Summary: April 2025

April 2025					July 2024 - Apri; 2025			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
150,001	138,772	11,229	8.1%	SPD	1,467,756	1,373,660	94,096	6.9%
259,095	271,981	(12,886)	(4.7%)	TANF Child	2,665,290	2,722,463	(57,173)	(2.1%)
128,909	138,495	(9,586)	(6.9%)	TANF Adult	1,307,832	1,380,669	(72,837)	(5.3%)
2,501	2,596	(95)	(3.7%)	LTC	24,903	26,036	(1,133)	(4.4%)
334,852	322,633	12,219	3.8%	MCE	3,377,608	3,230,838	146,770	4.5%
8,696	9,542	(846)	(8.9%)	WCM	95,311	95,539	(228)	(0.2%)
884,054	**884,019**	**35**	**0.0%**	**Medi-Cal Total**	**8,938,700**	**8,829,205**	**109,495**	**1.2%**
17,339	**17,488**	**(149)**	**(0.9%)**	**OneCare**	**172,216**	**174,285**	**(2,069)**	**(1.2%)**
506	**490**	**16**	**3.3%**	**PACE**	**5,035**	**4,789**	**246**	**5.1%**
538	**568**	**(30)**	**(5.3%)**	**MSSP**	**5,130**	**5,680**	**(550)**	**(9.7%)**
901,899	**901,997**	**(98)**	**(0.0%)**	**CalOptima Health Total**	**9,115,951**	**9,008,279**	**107,672**	**1.2%**

Note: MSSP enrollment is included in Medi-Cal Total.

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Consolidated Revenue & Expenses: April 2025 MTD

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	884,054	17,339		506	538		901,899
REVENUES							
Capitation Revenue	$ 350,473,962	$ 37,187,320	$ -	$ 4,614,796	$ 244,677	$ -	$ 392,520,755
Total Operating Revenue	**350,473,962**	**37,187,320**	**-**	**4,614,796**	**244,677**	**-**	**392,520,755**
MEDICAL EXPENSES							
Provider Capitation	113,604,885	14,751,004					128,355,889
Claims	137,135,685	6,827,426		1,794,089			145,757,200
MLTSS	49,283,169			96,179	45,790		49,425,138
Prescription Drugs		11,849,021		639,240			12,488,260
Case Mgmt & Other Medical	24,845,825	2,739,985		1,289,610	203,256		29,078,676
Total Medical Expenses	**324,869,565**	**36,167,436**	**-**	**3,819,118**	**249,046**	**-**	**365,105,164**
Medical Loss Ratio	*92.7%*	*97.3%*	*0.0%*	*82.8%*	*101.8%*	*0.0%*	*93.0%*
GROSS MARGIN	**25,604,398**	**1,019,885**	**-**	**795,678**	**(4,369)**	**-**	**27,415,591**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	11,834,993	1,047,833		179,843	108,533		13,171,201
Non-Salary Operating Expenses	3,985,854	752,841		152,209	1,422	81,818	4,974,142
Depreciation & Amortization	518,243			991			519,233
Other Operating Expenses	2,992,312	92,753		7,240	8,431		3,100,735
Indirect Cost Allocation, Occupancy	(677,761)	1,036,392		16,899	6,804		382,334
Total Administrative Expenses	**18,653,640**	**2,929,818**	**-**	**357,181**	**125,189**	**81,818**	**22,147,646**
Administrative Loss Ratio	*5.3%*	*7.9%*	*0.0%*	*7.7%*	*51.2%*	*0.0%*	*5.6%*
Operating Income/(Loss)	**6,950,758**	**(1,909,933)**	**-**	**438,497**	**(129,558)**	**(81,818)**	**5,267,946**
Investments and Other Non-Operating	5,571,658						25,273,805
CHANGE IN NET ASSETS	**$ 12,522,416**	**$ (1,909,933)**	**$ -**	**$ 438,497**	**$ (129,558)**	**$ (81,818)**	**$ 30,541,751**
BUDGETED CHANGE IN NET ASSETS	(14,785,594)	(873,382)	-	(40,610)	(114,418)	(916,666)	(11,360,115)
Variance to Budget - Fav/(Unfav)	$ 27,308,010	$ (1,036,551)	$ -	$ 479,107	$ (15,140)	$ 834,849	$ 41,901,866

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Consolidated Revenue & Expenses: April 2025 YTD

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	8,938,700	172,216		5,035	5,130		9,115,951
REVENUES							
Capitation Revenue	$ 3,866,512,329	$ 349,865,733	$ (3,197,365)	$ 44,640,986	$ 2,343,275	$ -	$ 4,260,164,958
Total Operating Revenue	**3,866,512,329**	**349,865,733**	**(3,197,365)**	**44,640,986**	**2,343,275**	**-**	**4,260,164,958**
MEDICAL EXPENSES							
Provider Capitation	1,139,003,544	148,346,630	(1,453,037)				1,285,897,137
Claims	1,308,768,505	61,282,047	(184,151)	16,123,496			1,385,989,897
MLTSS	486,998,408			194,226	383,469		487,576,103
Prescription Drugs		91,283,777		5,871,337			97,155,114
Case Mgmt & Other Medical	641,793,035	18,342,539		12,701,608	1,875,344		674,712,527
Total Medical Expenses	**3,576,563,492**	**319,254,993**	**(1,637,188)**	**34,890,668**	**2,258,813**	**-**	**3,931,330,778**
Medical Loss Ratio	*92.5%*	*91.3%*	*51.2%*	*78.2%*	*96.4%*	*0.0%*	*92.3%*
GROSS MARGIN	**289,948,837**	**30,610,740**	**(1,560,177)**	**9,750,318**	**84,462**	**-**	**328,834,180**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	114,504,223	10,752,727		1,697,780	1,027,176		127,981,906
Non-Salary Operating Expenses	35,157,193	5,805,901		807,292	14,208	207,719	41,992,313
Depreciation & Amortization	7,168,855			9,720			7,178,575
Other Operating Expenses	27,763,111	858,055		92,947	77,952		28,792,065
Indirect Cost Allocation, Occupancy	(7,739,270)	11,069,082		176,053	74,140		3,580,006
Total Administrative Expenses	**176,854,112**	**28,485,765**	**-**	**2,783,792**	**1,193,476**	**207,719**	**209,524,864**
Administrative Loss Ratio	*4.6%*	*8.1%*	*0.0%*	*6.2%*	*50.9%*	*0.0%*	*4.9%*
Operating Income/(Loss)	**113,094,724**	**2,124,975**	**(1,560,177)**	**6,966,526**	**(1,109,014)**	**(207,719)**	**119,309,315**
Investments and Other Non-Operating	5,586,320						160,311,484
CHANGE IN NET ASSETS	**$ 118,681,044**	**$ 2,124,975**	**$ (1,560,177)**	**$ 6,966,526**	**$ (1,109,014)**	**$ (207,719)**	**$ 279,620,799**
BUDGETED CHANGE IN NET ASSETS	(204,399,203)	(10,146,462)	-	(798,274)	(1,130,274)	(3,666,664)	(166,344,418)
Variance to Budget - Fav/(Unfav)	$ 323,080,247	$ 12,271,437	$ (1,560,177)	$ 7,764,800	$ 21,260	$ 3,458,945	$ 445,965,217

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BOARD

Balance Sheet: As of April 2025

ASSETS	
Current Assets	
Operating Cash	$647,124,850
Short-term Investments	1,310,577,272
Capitation Receivable	537,951,695
Receivables - Other	87,624,913
Prepaid Expenses	13,488,139
Total Current Assets	**2,596,766,869**
Capital Assets	
Capital Assets	195,758,388
Less Accumulated Depreciation	(95,494,720)
Capital Assets, Net of Depreciation	**100,263,668**
Other Assets	
Restricted Deposits	300,000
Board Designated Reserves	1,574,463,632
Statutory Designated Reserves	131,577,245
Total Other Assets	**1,706,340,877**
TOTAL ASSETS	**4,403,371,414**
Deferred Outflows	**75,899,007**
TOTAL ASSETS & DEFERRED OUTFLOWS	**4,479,270,421**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$105,118,422
Medical Claims Liability	1,221,299,157
Accrued Payroll Liabilities	25,847,041
Deferred Revenue	14,468,620
Other Current Liabilities	-
Capitation and Withholds	150,387,620
Total Current Liabilities	**1,517,120,861**
Other Liabilities	
GASB 96 Subscription Liabilities	17,058,702
Community Reinvestment	147,803,571
Capital Lease Payable	258,865
Postemployment Health Care Plan	17,697,644
Net Pension Liabilities	45,981,359
Total Other Liabilities	**228,800,141**
TOTAL LIABILITIES	**1,745,921,002**
Deferred Inflows	**8,646,445**
Net Position	
Required TNE	128,094,238
Funds in Excess of TNE	2,596,608,736
TOTAL NET POSITION	**2,724,702,974**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**4,479,270,421**

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Board Designated Reserve and TNE Analysis: As of April 2025

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	787,603,202				
MetLife Tier One	786,860,430				
Board Designated Reserves	1,574,463,632	1,019,185,884	1,630,697,415	555,277,748	(56,233,783)
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	65,917,144				
MetLife Tier Two	65,660,101				
Statutory Designated Reserves	131,577,245	128,094,238	140,903,661	3,483,007	(9,326,417)
Current Reserve Level (X min. TNE) [1]	*1.03*	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

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Spending Plan: As of April 2025

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 4/30/2025	**$2,724.7**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,574.5**			**57.8%**
	Statutory Designated Reserve[1]	**$131.6**			**4.8%**
	Capital Assets, net of Depreciation[2]	**$100.3**			**3.7%**
Resources Allocated[3]	Homeless Health Initiative[3]	$18.7	$66.0	$47.3	0.7%
	Housing and Homelessness Incentive Program[3]	21.9	87.4	65.5	0.8%
	Intergovernmental Transfers (IGT)	54.3	111.7	57.4	2.0%
	Digital Transformation and Workplace Modernization[4]	35.6	100.0	64.4	1.3%
	CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
	CalFresh and Redetermination Outreach Strategy	1.9	6.0	4.1	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	0.2	0.5	0.3	0.0%
	General Awareness Campaign	1.0	4.7	3.7	0.0%
	Member Health Needs Assessment	1.1	1.3	0.2	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	123.1	153.5	30.4	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)	17.6	18.0	0.4	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	6.1	107.5	101.4	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	3.6	7.6	4.0	0.1%
	Quality Initiatives from unearned Pay for Value Program	18.7	23.3	4.6	0.7%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.5	1.2	0.7	0.0%
	Medi-Cal Provider Rate Increases	350.8	526.2	175.4	12.9%
	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:	**$788.4**	**$1,422.5**	**$634.0**	**28.9%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$130.0**			**4.8%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 157 days of CalOptima Health's current operations.
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements.
[3] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.
[4] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

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Homeless Health Initiative and Allocated Funds: As of April 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 & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	0
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	904,651	58,610
FQHC (Community Health Center) Expansion	21,902	21,902	0
HCAP and CalOptima Health Days	9,888,914	4,198,885	5,690,028
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine[1]	14,376,652	7,371,161	7,005,491
Outreach and Engagement	7,000,000	1,138,008	5,861,992
Housing and Homelessness Incentive Program (HHIP)[2]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$106,100,000**	**$47,271,655**	**$58,828,345**
Transfer of funds to HHIP[2]	(40,100,000)	-	(40,100,000)
Program Total	**$66,000,000**	**$47,271,655**	**$18,728,345**

Notes:

[1]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 to Healthcare in Action (Anaheim) and Celebrating Life Community Health Center (Costa Mesa).

[2]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP.

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Housing and Homelessness Incentive Program
As of April 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**	

Notes:

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments.

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UNAUDITED FINANCIAL STATEMENTS

April 30, 2025

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CalOptima Health - Consolidated
Financial Highlights
For the Ten Months Ending April 30, 2025

April 2025					July 2024 - April 2025			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
901,899	901,997	(98)	(0.0%)	Member Months	9,115,951	9,008,279	107,672	1.2%
392,520,755	359,983,298	32,537,457	9.0%	Revenues	4,260,164,958	3,572,238,549	687,926,409	19.3%
365,105,164	351,028,604	(14,076,560)	(4.0%)	Medical Expenses	3,931,330,778	3,545,190,357	(386,140,421)	(10.9%)
22,147,646	25,685,364	3,537,718	13.8%	Administrative Expenses	209,524,864	247,189,069	37,664,205	15.2%
5,267,946	**(16,730,670)**	**21,998,616**	**131.5%**	**Operating Margin**	**119,309,315**	**(220,140,877)**	**339,450,192**	**154.2%**
				Non-Operating Income (Loss)				
19,743,475	6,666,660	13,076,815	196.2%	Net Investment Income/Expense	169,331,253	66,666,600	102,664,653	154.0%
(13,813)	(117,280)	103,467	88.2%	Net Rental Income/Expense	(377,142)	(1,172,800)	795,658	67.8%
5,594,045	-	5,594,045	100.0%	Net MCO Tax	5,584,111	-	5,584,111	100.0%
(27,515)	(1,178,825)	1,151,310	97.7%	Grant Expense	(14,228,947)	(11,697,341)	(2,531,606)	(21.6%)
-	-	-	0.0%	Net QAF/IGT	-	-	-	0.0%
(22,386)	-	(22,386)	(100.0%)	Other Income/Expense	2,209	-	2,209	100.0%
25,273,805	**5,370,555**	**19,903,250**	**370.6%**	**Total Non-Operating Income (Loss)**	**160,311,484**	**53,796,459**	**106,515,025**	**198.0%**
30,541,751	**(11,360,115)**	**41,901,866**	**368.9%**	**Change in Net Assets**	**279,620,799**	**(166,344,418)**	**445,965,217**	**268.1%**
93.0%	*97.5%*	*(4.5%)*		*Medical Loss Ratio*	*92.3%*	*99.2%*	*(7.0%)*	
5.6%	*7.1%*	*1.5%*		*Administrative Loss Ratio*	*4.9%*	*6.9%*	*2.0%*	
1.3%	*(4.6%)*	*6.0%*		*Operating Margin Ratio*	*2.8%*	*(6.2%)*	*9.0%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
87.3%	*92.7%*	*(5.3%)*		**Adjusted MLR*	*86.0%*	*94.3%*	*(8.4%)*	
5.6%	*7.1%*	*1.5%*		**Adjusted ALR*	*5.4%*	*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 - Consolidated
Full Time Equivalent (FTE) Data
For the Ten Months Ending April 30, 2025

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1,320	1,361	41
OneCare	171	186	15
PACE	107	113	6
MSSP	23	25	2
Total	1,620	1,685	64

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	13,045	13,608	563
OneCare	1,711	1,861	150
PACE	1,068	1,130	62
MSSP	214	250	36
Total	16,039	16,849	810

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	670	650	(20)
OneCare	102	94	(8)
PACE	5	4	(1)
MSSP	24	23	(1)
Consolidated	557	535	(22)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	685	649	(36)
OneCare	101	94	(7)
PACE	5	4	(1)
MSSP	24	23	(1)
Consolidated	568	535	(33)

Open FTE			
	Total	Medical	Admin
Medi-Cal	63	33	30
OneCare	11	7	4
PACE	9	3	6
MSSP	0	0	0
Total	83	43	40

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending April 30, 2025

MEMBER MONTHS		901,899		901,997		(98)
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$350,473,962	$396.44	$319,441,801	$361.35	$31,032,161	$35.09
OneCare	37,187,320	2,144.72	36,176,247	2,068.63	1,011,073	76.09
OneCare Connect	-		-		-	-
PACE	4,614,796	9,120.15	4,111,733	8,391.29	503,063	728.86
MSSP	244,677	454.79	253,517	446.33	(8,840)	8.46
Covered CA	-	0.00	-	0.00	-	0.00
Total Operating Revenue	392,520,755	435.22	359,983,298	399.10	32,537,457	36.12
MEDICAL EXPENSES						
Medi-Cal	324,869,565	367.48	313,134,635	354.22	(11,734,930)	(13.26)
OneCare	36,167,436	2,085.90	33,799,999	1,932.75	(2,367,437)	(153.15)
OneCare Connect					-	0.00
PACE	3,819,118	7,547.66	3,853,229	7,863.73	34,111	316.07
MSSP	249,046	462.91	240,741	423.84	(8,305)	(39.07)
Covered CA		-		-	-	-
Total Medical Expenses	365,105,164	404.82	351,028,604	389.17	(14,076,560)	(15.65)
GROSS MARGIN	27,415,591	30.40	8,954,694	9.93	18,460,897	20.47
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	13,171,201	14.60	13,632,306	15.11	461,105	0.51
Professional Fees	1,302,907	1.44	2,720,011	3.02	1,417,104	1.58
Purchased Services	2,993,913	3.32	3,231,230	3.58	237,317	0.26
Printing & Postage	677,322	0.75	657,295	0.73	(20,027)	(0.02)
Depreciation & Amortization	519,233	0.58	1,027,958	1.14	508,725	0.56
Other Expenses	3,100,735	3.44	3,972,631	4.40	871,896	0.96
Indirect Cost Allocation, Occupancy	382,334	0.42	443,933	0.49	61,599	0.07
Total Administrative Expenses	22,147,646	24.56	25,685,364	28.48	3,537,718	3.92
NET INCOME (LOSS) FROM OPERATIONS	5,267,946	5.84	(16,730,670)	(18.55)	21,998,616	24.39
INVESTMENT INCOME						
Interest Income	14,469,526	16.04	6,666,660	7.39	7,802,866	8.65
Realized Gain/(Loss) on Investments	1,629,436	1.81	-	-	1,629,436	1.81
Unrealized Gain/(Loss) on Investments	3,644,513	4.04	-	-	3,644,513	4.04
Total Investment Income	19,743,475	21.89	6,666,660	7.39	13,076,815	14.50
NET RENTAL INCOME/EXPENSE	(13,813)	(0.02)	(117,280)	(0.13)	103,467	0.11
NET MCO TAX	5,594,045	6.20	-	-	5,594,045	6.20
GRANT EXPENSE	(27,515)	(0.03)	(1,178,825)	(1.31)	1,151,310	1.28
OTHER INCOME/EXPENSE	(22,386)	(0.02)	-	-	(22,386)	(0.02)
CHANGE IN NET ASSETS	**30,541,751**	**33.86**	**(11,360,115)**	**(12.59)**	**41,901,866**	**46.45**
MEDICAL LOSS RATIO	**93.0%**		**97.5%**		**(4.5%)**	
ADMINISTRATIVE LOSS RATIO	**5.6%**		**7.1%**		**1.5%**	

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CalOptima Health- Consolidated - Year to Date
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2025

MEMBER MONTHS		9,115,951		9,008,279		107,672
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$3,866,512,329	$432.56	$3,175,247,747	$359.63	$691,264,582	$72.93
OneCare	349,865,733	2,031.55	354,512,781	2,034.10	(4,647,048)	(2.55)
OneCare Connect	(3,197,365)		-		(3,197,365)	0.00
PACE	44,640,986	8,866.13	39,942,851	8,340.54	4,698,135	525.59
MSSP	2,343,275	456.78	2,535,170	446.33	(191,895)	10.45
Covered CA	-	0.00	-	0.00	-	0.00
Total Operating Revenue	4,260,164,958	467.33	3,572,238,549	396.55	687,926,409	70.78
MEDICAL EXPENSES						
Medi-Cal	3,576,563,492	400.12	3,172,466,851	359.32	(404,096,641)	(40.80)
OneCare	319,254,993	1,853.81	332,542,304	1,908.04	13,287,311	54.23
OneCare Connect	(1,637,188)				1,637,188	0.00
PACE	34,890,668	6,929.63	37,773,792	7,887.62	2,883,124	957.99
MSSP	2,258,813	440.31	2,407,410	423.84	148,597	(16.47)
Covered CA		0.00		0.00	-	0.00
Total Medical Expenses	3,931,330,778	431.26	3,545,190,357	393.55	(386,140,421)	(37.71)
GROSS MARGIN	328,834,180	36.07	27,048,192	3.00	301,785,988	33.07
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	127,981,906	14.04	134,797,525	14.96	6,815,619	0.92
Professional Fees	13,583,150	1.49	20,542,691	2.28	6,959,541	0.79
Purchased Services	23,272,180	2.55	30,281,663	3.36	7,009,483	0.81
Printing & Postage	5,136,982	0.56	7,778,227	0.86	2,641,245	0.30
Depreciation & Amortization	7,178,575	0.79	10,279,580	1.14	3,101,005	0.35
Other Expenses	28,792,065	3.16	39,072,503	4.34	10,280,438	1.18
Indirect Cost Allocation, Occupancy	3,580,006	0.39	4,436,880	0.49	856,874	0.10
Total Administrative Expenses	209,524,864	22.98	247,189,069	27.44	37,664,205	4.46
NET INCOME (LOSS) FROM OPERATIONS	119,309,315	13.09	(220,140,877)	(24.44)	339,450,192	37.53
INVESTMENT INCOME						
Interest Income	144,778,876	15.88	66,666,600	7.40	78,112,276	8.48
Realized Gain/(Loss) on Investments	4,690,604	0.51	-	0.00	4,690,604	0.51
Unrealized Gain/(Loss) on Investments	19,861,773	2.18	-	0.00	19,861,773	2.18
Total Investment Income	169,331,253	18.58	66,666,600	7.40	102,664,653	11.18
NET RENTAL INCOME/EXPENSE	(377,142)	(0.04)	(1,172,800)	(0.13)	795,658	0.09
NET MCO TAX	5,584,111	0.61	-	0.00	5,584,111	0.61
GRANT EXPENSE	(14,228,947)	(1.56)	(11,697,341)	(1.30)	(2,531,606)	(0.26)
OTHER INCOME/EXPENSE	2,209	0.00	-	0.00	2,209	0.00
CHANGE IN NET ASSETS	**279,620,799**	**30.67**	**(166,344,418)**	**(18.47)**	**445,965,217**	**49.14**
MEDICAL LOSS RATIO	**92.3%**		**99.2%**		**(7.0%)**	
ADMINISTRATIVE LOSS RATIO	**4.9%**		**6.9%**		**2.0%**	

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CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending April 30, 2025

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	884,054	17,339		506	538	-	901,899
REVENUES							
Capitation Revenue	$ 350,473,962	$ 37,187,320	$ -	$ 4,614,796	$ 244,677	$ -	$ 392,520,755
Total Operating Revenue	**350,473,962**	**37,187,320**	**-**	**4,614,796**	**244,677**	**-**	**392,520,755**
MEDICAL EXPENSES							
Provider Capitation	113,604,885	14,751,004					128,355,889
Claims	137,135,685	6,827,426		1,794,089			145,757,200
MLTSS	49,283,169			96,179	45,790		49,425,138
Prescription Drugs		11,849,021		639,240			12,488,260
Case Mgmt & Other Medical	24,845,825	2,739,985		1,289,610	203,256		29,078,676
Total Medical Expenses	**324,869,565**	**36,167,436**	**-**	**3,819,118**	**249,046**	**-**	**365,105,164**
Medical Loss Ratio	*92.7%*	*97.3%*	*0.0%*	*82.8%*	*101.8%*	*0.0%*	*93.0%*
GROSS MARGIN	**25,604,398**	**1,019,885**	**-**	**795,678**	**(4,369)**	**-**	**27,415,591**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	11,834,993	1,047,833		179,843	108,533		13,171,201
Non-Salary Operating Expenses	3,985,854	752,841		152,209	1,422	81,818	4,974,142
Depreciation & Amortization	518,243			991			519,233
Other Operating Expenses	2,992,312	92,753		7,240	8,431		3,100,735
Indirect Cost Allocation, Occupancy	(677,761)	1,036,392		16,899	6,804		382,334
Total Administrative Expenses	**18,653,640**	**2,929,818**	**-**	**357,181**	**125,189**	**81,818**	**22,147,646**
Administrative Loss Ratio	*5.3%*	*7.9%*	*0.0%*	*7.7%*	*51.2%*	*0.0%*	*5.6%*
Operating Income/(Loss)	**6,950,758**	**(1,909,933)**	**-**	**438,497**	**(129,558)**	**(81,818)**	**5,267,946**
Investments and Other Non-Operating	5,571,658						25,273,805
CHANGE IN NET ASSETS	**$ 12,522,416**	**$ (1,909,933)**	**$ -**	**$ 438,497**	**$ (129,558)**	**$ (81,818)**	**$ 30,541,751**
BUDGETED CHANGE IN NET ASSETS	(14,785,594)	(873,382)	-	(40,610)	(114,418)	(916,666)	(11,360,115)
Variance to Budget - Fav/(Unfav)	$ 27,308,010	$ (1,036,551)	$ -	$ 479,107	$ (15,140)	$ 834,849	$ 41,901,866

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CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Ten Months Ending April 30, 2025

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	8,938,700	172,216		5,035	5,130	-	9,115,951
REVENUES							
Capitation Revenue	$ 3,866,512,329	$ 349,865,733	$ (3,197,365)	$ 44,640,986	$ 2,343,275	$ -	$ 4,260,164,958
Total Operating Revenue	**3,866,512,329**	**349,865,733**	**(3,197,365)**	**44,640,986**	**2,343,275**	**-**	**4,260,164,958**
MEDICAL EXPENSES							
Provider Capitation	1,139,003,544	148,346,630	(1,453,037)				1,285,897,137
Claims	1,308,768,505	61,282,047	(184,151)	16,123,496			1,385,989,897
MLTSS	486,998,408			194,226	383,469		487,576,103
Prescription Drugs		91,283,777		5,871,337			97,155,114
Case Mgmt & Other Medical	641,793,035	18,342,539		12,701,608	1,875,344		674,712,527
Total Medical Expenses	**3,576,563,492**	**319,254,993**	**(1,637,188)**	**34,890,668**	**2,258,813**	**-**	**3,931,330,778**
Medical Loss Ratio	*92.5%*	*91.3%*	*0.0%*	*78.2%*	*96.4%*	*0.0%*	*92.3%*
GROSS MARGIN	**289,948,837**	**30,610,740**	**(1,560,177)**	**9,750,318**	**84,462**	**-**	**328,834,180**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	114,504,223	10,752,727		1,697,780	1,027,176		127,981,906
Non-Salary Operating Expenses	35,157,193	5,805,901		807,292	14,208	207,719	41,992,313
Depreciation & Amortization	7,168,855			9,720			7,178,575
Other Operating Expenses	27,763,111	858,055		92,947	77,952		28,792,065
Indirect Cost Allocation, Occupancy	(7,739,270)	11,069,082		176,053	74,140		3,580,006
Total Administrative Expenses	**176,854,112**	**28,485,765**	**-**	**2,783,792**	**1,193,476**	**207,719**	**209,524,864**
Administrative Loss Ratio	*4.6%*	*8.1%*	*0.0%*	*6.2%*	*50.9%*	*0.0%*	*4.9%*
Operating Income/(Loss)	**113,094,724**	**2,124,975**	**(1,560,177)**	**6,966,526**	**(1,109,014)**	**(207,719)**	**119,309,315**
Investments and Other Non-Operating	5,586,320						160,311,484
CHANGE IN NET ASSETS	**$ 118,681,044**	**$ 2,124,975**	**$ (1,560,177)**	**$ 6,966,526**	**$ (1,109,014)**	**$ (207,719)**	**$ 279,620,799**
BUDGETED CHANGE IN NET ASSETS	(204,399,203)	(10,146,462)	-	(798,274)	(1,130,274)	(3,666,664)	(166,344,418)
Variance to Budget - Fav/(Unfav)	$ 323,080,247	$ 12,271,437	$ (1,560,177)	$ 7,764,800	$ 21,260	$ 3,458,945	$ 445,965,217

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CalOptima Health

Highlights – Consolidated, for Ten Months Ending April 30, 2025

MONTH TO DATE RESULTS:

- Change in Net Assets is $30.5 million, favorable to budget $41.9 million
- Operating surplus is $5.3 million, with a surplus in non-operating income of $25.3 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $279.6 million, favorable to budget $446.0 million
- Operating surplus is $119.3 million, with a surplus in non-operating income of $160.3 million

Change in Net Assets by Line of Business (LOB) ($ millions):

April 2025				July 2024 - April 2025		
Actual	**Budget**	**Variance**	**Operating Income (Loss)**	**Actual**	**Budget**	**Variance**
7.0	(14.8)	21.7	Medi-Cal	113.1	(204.4)	317.5
(1.9)	(0.9)	(1.0)	OneCare	2.1	(10.1)	12.3
0.4	0.0	0.5	PACE	7.0	(0.8)	7.8
(0.1)	(0.1)	0.0	MSSP	(1.1)	(1.1)	0.0
0.0	0.0	0.0	OCC	(1.6)	0.0	(1.6)
(0.1)	(0.9)	0.8	Covered CA	(0.2)	(3.7)	3.5
5.3	**(16.7)**	**22.0**	**Total Operating Income (Loss)**	**119.3**	**(220.1)**	**339.5**
			Non-Operating Income (Loss)			
19.7	6.7	13.1	Net Investment Income/Expense	169.3	66.7	102.7
0.0	0.0	0.0	Net QAF & IGT Income/Expense	0.0	0.0	0.0
0.0	0.0	0.0	Other Income/Expense	0.0	0.0	0.0
25.3	**5.4**	**19.9**	**Total Non-Operating Income/(Loss)**	**160.3**	**53.8**	**106.5**
30.5	**(11.4)**	**41.9**	**TOTAL**	**279.6**	**(166.3)**	**446.0**

CalOptima Health - Consolidated
Enrollment Summary
For the Ten Months Ending April 30, 2025

April 2025					July 2024 - April 2025			
Actual	**Budget**	**$ Variance**	**%Variance**	**Enrollment (by Aid Category)**	**Actual**	**Budget**	**$ Variance**	**%Variance**
150,001	138,772	11,229	8.1%	SPD	1,467,756	1,373,660	94,096	6.9%
259,095	271,981	(12,886)	(4.7%)	TANF Child	2,665,290	2,722,463	(57,173)	(2.1%)
128,909	138,495	(9,586)	(6.9%)	TANF Adult	1,307,832	1,380,669	(72,837)	(5.3%)
2,501	2,596	(95)	(3.7%)	LTC	24,903	26,036	(1,133)	(4.4%)
334,852	322,633	12,219	3.8%	MCE	3,377,608	3,230,838	146,770	4.5%
8,696	9,542	(846)	(8.9%)	WCM	95,311	95,539	(228)	(0.2%)
884,054	**884,019**	**35**	**0.0%**	**Medi-Cal Total**	**8,938,700**	**8,829,205**	**109,495**	**1.2%**
17,339	**17,488**	**(149)**	**(0.9%)**	**OneCare**	**172,216**	**174,285**	**(2,069)**	**(1.2%)**
506	**490**	**16**	**3.3%**	**PACE**	**5,035**	**4,789**	**246**	**5.1%**
538	**568**	**(30)**	**(5.3%)**	**MSSP**	**5,130**	**5,680**	**(550)**	**(9.7%)**
901,899	**901,997**	**(98)**	**(0.0%)**	**CalOptima Health Total**	**9,115,951**	**9,008,279**	**107,672**	**1.2%**
				Enrollment (by Network)				
348,589	302,784	45,805	15.1%	HMO	3,299,707	3,030,874	268,833	8.9%
167,605	178,761	(11,156)	(6.2%)	PHC	1,732,648	1,788,007	(55,359)	(3.1%)
66,817	132,558	(65,741)	(49.6%)	Shared Risk Group	980,393	1,329,711	(349,318)	(26.3%)
301,043	269,916	31,127	11.5%	Fee for Service	2,925,952	2,680,613	245,339	9.2%
884,054	**884,019**	**35**	**0.0%**	**Medi-Cal Total**	**8,938,700**	**8,829,205**	**109,495**	**1.2%**
17,339	**17,488**	**(149)**	**(0)**	**OneCare**	**172,216**	**174,285**	**(2,069)**	**(0)**
506	**490**	**16**	**3.3%**	**PACE**	**5,035**	**4,789**	**246**	**5.1%**
538	**568**	**(30)**	**(5.3%)**	**MSSP**	**5,130**	**5,680**	**(550)**	**(9.7%)**
901,899	**901,997**	**(98)**	**(0.0%)**	**CalOptima Health Total**	**9,115,951**	**9,008,279**	**107,672**	**1.2%**

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			189,462	164,358	25,104
TANF Child	66,405	65,921	65,198	64,503	77,875	77,766	77,607	76,962	75,128	74,225			721,590	690,543	31,047
TANF Adult	54,590	55,734	55,056	54,535	70,864	70,611	70,439	69,398	68,589	68,129			637,945	629,627	8,318
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			1,737,216	1,532,535	204,681
WCM	1,241	1,234	1,214	1,163	1,370	1,479	1,514	1,430	1,429	1,412			13,486	13,811	(325)
Total	292,966	293,002	290,207	288,128	360,687	359,712	359,631	355,795	350,990	348,589			3,299,707	3,030,874	**268,833**
PHCs															
SPD	4,906	4,644	4,820	4,796	4,736	4,780	4,737	4,799	4,812	4,820			47,850	45,109	2,741
TANF Child	140,053	138,903	137,874	136,823	136,101	135,163	133,694	132,827	131,272	130,720			1,353,430	1,411,933	(58,503)
TANF Adult	3,994	4,186	4,191	4,104	4,165	4,170	4,132	4,089	4,023	4,021			41,075	50,461	(9,386)
LTC													0		0
MCE	22,999	22,762	22,600	22,551	22,507	22,511	22,520	22,277	21,942	21,838			224,507	216,236	8,271
WCM	6,571	7,308	6,733	6,550	6,336	6,573	6,580	6,496	6,433	6,206			65,786	64,268	1,518
Total	178,523	177,803	176,218	174,824	173,845	173,197	171,663	170,488	168,482	167,605			1,732,648	1,788,007	**(55,359)**
Shared Risk Groups															
SPD	7,270	7,077	7,057	7,133	3,422	3,411	3,353	3,413	3,321	3,422			48,879	64,920	(16,041)
TANF Child	32,783	32,842	32,545	32,325	18,564	18,412	18,308	18,287	18,168	18,156			240,390	313,909	(73,519)
TANF Adult	27,519	29,041	28,870	28,586	11,818	11,756	11,734	11,438	11,353	11,227			183,342	290,251	(106,909)
LTC				1									1	10	(9)
MCE	74,704	74,918	74,517	74,138	34,102	34,260	34,467	34,469	34,145	33,995			503,715	653,250	(149,535)
WCM	702	701	716	707	91	362	367	254	149	17			4,066	7,371	(3,305)
Total	**142,978**	**144,579**	**143,705**	**142,890**	**67,997**	**68,201**	**68,229**	**67,861**	**67,136**	**66,817**			**980,393**	**1,329,711**	**(349,318)**
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			1,026,260	950,844	75,416
TANF Child													0	12	(12)
TANF Adult	1,145	1,159	1,123	1,052	1,035	1,056	1,037	1,011	937	930			10,485	18,359	(7,874)
LTC	2,178	2,203	2,209	2,222	2,208	2,237	2,234	2,204	2,216	2,218			22,129	23,339	(1,210)
MCE	4,008	4,703	4,593	4,431	4,388	4,283	4,088	3,863	3,645	3,457			41,459	91,153	(49,694)
WCM	6	7	8	15	12	12	13	13	12	15			113	90	23
Total	**107,630**	**107,864**	**108,230**	**108,706**	**109,567**	**110,471**	**111,414**	**111,713**	**112,198**	**112,653**			**1,100,446**	**1,083,797**	**16,649**
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			155,305	148,429	6,876
TANF Child	32,741	33,377	33,868	33,995	34,269	36,369	36,010	36,850	36,407	35,994			349,880	306,066	43,814
TANF Adult	40,618	42,145	42,625	42,860	43,229	44,456	44,366	45,308	44,776	44,602			434,985	391,971	43,014
LTC	278	254	271	278	285	295	270	289	262	283			2,765	2,687	78
MCE	80,536	82,491	83,546	83,778	84,679	89,895	89,750	92,778	91,844	91,414			870,711	737,664	133,047
WCM	1,205	1,184	1,178	1,114	1,177	1,198	1,369	1,246	1,143	1,046			11,860	9,999	1,861
Total	**171,014**	**174,887**	**177,356**	**177,844**	**179,564**	**188,545**	**186,622**	**191,603**	**189,681**	**188,390**			**1,825,506**	**1,596,816**	**228,690**
Grand Totals															
SPD	145,255	143,460	144,652	145,508	146,300	147,617	147,236	148,457	149,270	150,001			1,467,756	1,373,660	94,096
TANF Child	271,982	271,043	269,485	267,646	266,809	267,710	265,619	264,926	260,975	259,095			2,665,290	2,722,463	(57,173)
TANF Adult	127,866	132,265	131,865	131,137	131,111	132,049	131,708	131,244	129,678	128,909			1,307,832	1,380,669	(72,837)
LTC	2,458	2,457	2,480	2,501	2,494	2,532	2,507	2,495	2,478	2,501			24,903	26,036	(1,133)
MCE	335,825	338,476	337,385	336,051	335,960	340,594	340,646	340,899	336,920	334,852			3,377,608	3,230,838	146,770
WCM	9,725	10,434	9,849	9,549	8,986	9,624	9,843	9,439	9,166	8,696			95,311	95,539	(228)
Total MediCal MM	**893,111**	**898,135**	**895,716**	**892,392**	**891,660**	**900,126**	**897,559**	**897,460**	**888,487**	**884,054**			**8,938,700**	**8,829,205**	**109,495**
OneCare	**17,311**	**17,307**	**17,282**	**17,173**	**17,156**	**17,037**	**17,090**	**17,238**	**17,283**	**17,339**			**172,216**	**174,285**	**(2,069)**
PACE	**506**	**508**	**503**	**498**	**502**	**506**	**502**	**503**	**501**	**506**			**5,035**	**4,789**	**246**
MSSP	**473**	**480**	**487**	**506**	**524**	**519**	**533**	**538**	**532**	**538**			**5,130**	**5,680**	**(550)**
Covered CA	**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**			**9,115,951**	**9,008,279**	**107,672**

Note:* Total membership does not include MSSP

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ENROLLMENT– APRIL MONTH:

Overall, April enrollment was 901,899

- Unfavorable to budget 98 or 0.0%
- Decreased 4,372 or 0.5% from Prior Month (PM) (March 2025)
- Decreased 26,531 or 2.9% from Prior Year (PY) (April 2024)

Medi-Cal enrollment was 884,054

- Favorable to budget 35 or 0.0%
- Medi-Cal Expansion (MCE) favorable to budget 12,219
- Seniors and Persons with Disabilities (SPD) favorable to budget 11,229
- Temporary Assistance for Needy Families (TANF) unfavorable to budget 22,472
- Whole Child Model (WCM) unfavorable to budget 846
- Long-Term Care (LTC) unfavorable to budget 95
- Decreased 4,433 or 0.5% from PM

OneCare enrollment was 17,339

- Unfavorable to budget 149 or 0.9%
- Increased 56 or 0.3% from PM

PACE enrollment was 506

- Favorable to budget 16 or 3.3%
- Increased 5 or 1.0% from PM

MSSP enrollment was 538

- Unfavorable to budget 30 or 5.3%
- Increased 6 or 1.1% from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2025

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
884,054	**884,019**	**35**	**0.0%**	**Member Months**	**8,938,700**	**8,829,205**	**109,495**	**1.2%**
				Revenues				
350,473,962	319,441,801	31,032,161	9.7%	Medi-Cal Capitation Revenue	3,866,512,329	3,175,247,747	691,264,582	21.8%
350,473,962	**319,441,801**	**31,032,161**	**9.7%**	**Total Operating Revenue**	**3,866,512,329**	**3,175,247,747**	**691,264,582**	**21.8%**
				Medical Expenses				
113,604,885	111,463,090	(2,141,795)	(1.9%)	Provider Capitation	1,139,003,544	1,115,508,977	(23,494,567)	(2.1%)
62,758,082	65,144,877	2,386,795	3.7%	Facilities Claims	643,618,638	650,243,517	6,624,879	1.0%
74,377,603	65,854,327	(8,523,276)	(12.9%)	Professional Claims	665,149,867	678,195,390	13,045,523	1.9%
49,283,169	48,905,864	(377,305)	(0.8%)	MLTSS	486,998,408	487,249,120	250,712	0.1%
9,635,506	10,159,744	524,238	5.2%	Incentive Payments	117,647,394	131,654,372	14,006,978	10.6%
8,740,345	9,776,526	1,036,181	10.6%	Medical Management	84,303,114	91,313,393	7,010,279	7.7%
6,469,974	1,830,207	(4,639,767)	(253.5%)	Other Medical Expenses	439,842,528	18,302,082	(421,540,446)	(2,303.2%)
324,869,565	**313,134,635**	**(11,734,930)**	**(3.7%)**	**Total Medical Expenses**	**3,576,563,492**	**3,172,466,851**	**(404,096,641)**	**(12.7%)**
25,604,398	**6,307,166**	**19,297,232**	**306.0%**	**Gross Margin**	**289,948,837**	**2,780,896**	**287,167,941**	**10,326.5%**
				Administrative Expenses				
11,834,993	12,124,860	289,867	2.4%	Salaries, Wages & Employee Benefits	114,504,223	119,904,709	5,400,486	4.5%
1,065,257	1,651,187	585,930	35.5%	Professional Fees	12,421,655	15,536,797	3,115,142	20.1%
2,406,059	2,586,796	180,737	7.0%	Purchased Services	19,001,080	24,609,090	5,608,010	22.8%
514,537	481,815	(32,722)	(6.8%)	Printing & Postage	3,734,458	5,288,337	1,553,879	29.4%
518,243	1,026,358	508,115	49.5%	Depreciation & Amortization	7,168,855	10,263,580	3,094,725	30.2%
2,992,312	3,828,175	835,863	21.8%	Other Operating Expenses	27,763,111	37,641,896	9,878,785	26.2%
(677,761)	(606,431)	71,330	11.8%	Indirect Cost Allocation, Occupancy	(7,739,270)	(6,064,310)	1,674,960	27.6%
18,653,640	**21,092,760**	**2,439,120**	**11.6%**	**Total Administrative Expenses**	**176,854,112**	**207,180,099**	**30,325,987**	**14.6%**
				Non-Operating Income (Loss)				
5,594,045	-	5,594,045	100.0%	Net Operating Tax	5,584,111	-	5,584,111	100.0%
(22,386)	-	(22,386)	(100.0%)	Other Income/Expense	2,209	-	2,209	100.0%
5,571,658	**-**	**5,571,658**	**100.0%**	**Total Non-Operating Income (Loss)**	**5,586,320**	**-**	**5,586,320**	**100.0%**
12,522,416	**(14,785,594)**	**27,308,010**	**184.7%**	**Change in Net Assets**	**118,681,044**	**(204,399,203)**	**323,080,247**	**158.1%**
92.7%	***98.0%***	***(5.3%)***		***Medical Loss Ratio***	***92.5%***	***99.9%***	***(7.4%)***	
5.3%	***6.6%***	***1.3%***		***Admin Loss Ratio***	***4.6%***	***6.5%***	***2.0%***	

MEDI-CAL INCOME STATEMENT– APRIL MONTH:

REVENUES are $350.5 million, favorable to budget $31.0 million:

- Favorable price related variance of $31.0 million
  - $21.1 million due to favorable member mix and draft Calendar Year (CY) 2025 capitation rates from the Department of Health Care Services (DHCS)
  - $23.7 million due to Quality Withhold and Incentive (QWI) accrual for CY 2024 and 2025
  - Offset by:
    - $13.4 million from Proposition 56, Enhanced Care Management (ECM) and Unsatisfactory Immigration Status (UIS) risk corridors

MEDICAL EXPENSES are $324.9 million, unfavorable to budget $11.7 million:

- Unfavorable price related variance of $11.7 million:
  - Professional Claims expense unfavorable variance of $8.5 million due to an increase in utilization in Physician Services and Mental Health
  - Other Medical Expenses unfavorable variance of $4.6 million due to CY 2025 Community Reinvestment and Quality Achievement
  - Provider Capitation expenses unfavorable variance of $2.1 million
  - Offset by:
    - Facilities Claims expenses favorable variance of $2.4 million due to lower than expected utilization
    - Medical Management expenses favorable variance of $1.0 million

ADMINISTRATIVE EXPENSES are $18.7 million, favorable to budget $2.4 million:

- Non-Salary expenses favorable to budget $2.1 million
- Salaries, Wages & Employee Benefits expenses favorable to budget $0.3 million

CHANGE IN NET ASSETS is $12.5 million, favorable to budget $27.3 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
17,339	**17,488**	**(149)**	**(0.9%)**	**Member Months**	**172,216**	**174,285**	**(2,069)**	**(1.2%)**
				Revenues				
25,486,186	26,667,855	(1,181,669)	(4.4%)	Medicare Part C Revenue	252,702,022	260,254,801	(7,552,779)	(2.9%)
11,701,135	9,508,392	2,192,743	23.1%	Medicare Part D Revenue	97,163,711	94,257,980	2,905,731	3.1%
37,187,320	**36,176,247**	**1,011,073**	**2.8%**	**Total Operating Revenue**	**349,865,733**	**354,512,781**	**(4,647,048)**	**(1.3%)**
				Medical Expenses				
14,751,004	16,276,890	1,525,886	9.4%	Provider Capitation	148,346,630	158,903,810	10,557,180	6.6%
4,420,521	4,934,311	513,790	10.4%	Inpatient	42,011,952	48,618,473	6,606,521	13.6%
2,406,905	1,731,041	(675,864)	(39.0%)	Ancillary	19,270,095	17,313,242	(1,956,853)	(11.3%)
11,849,021	8,913,858	(2,935,163)	(32.9%)	Prescription Drugs	91,283,777	88,940,125	(2,343,652)	(2.6%)
897,015	497,393	(399,622)	(80.3%)	Incentive Payments	6,378,407	4,947,045	(1,431,362)	(28.9%)
1,013,263	1,446,506	433,243	30.0%	Medical Management	10,025,275	13,819,609	3,794,334	27.5%
829,707	-	(829,707)	(100.0%)	Other Medical Expenses	1,938,858	-	(1,938,858)	(100.0%)
36,167,436	**33,799,999**	**(2,367,437)**	**(7.0%)**	**Total Medical Expenses**	**319,254,993**	**332,542,304**	**13,287,311**	**4.0%**
1,019,885	**2,376,248**	**(1,356,363)**	**(57.1%)**	**Gross Margin**	**30,610,740**	**21,970,477**	**8,640,263**	**39.3%**
				Administrative Expenses				
1,047,833	1,222,650	174,817	14.3%	Salaries, Wages & Employee Benefits	10,752,727	12,080,119	1,327,392	11.0%
152,124	142,033	(10,091)	(7.1%)	Professional Fees	879,849	1,237,680	357,831	28.9%
460,110	571,960	111,850	19.6%	Purchased Services	3,658,128	5,003,420	1,345,292	26.9%
140,607	164,950	24,343	14.8%	Printing & Postage	1,267,923	2,318,500	1,050,577	45.3%
92,753	121,954	29,201	23.9%	Other Operating Expenses	858,055	1,216,390	358,335	29.5%
1,036,392	1,026,083	(10,309)	(1.0%)	Indirect Cost Allocation, Occupancy	11,069,082	10,260,830	(808,252)	(7.9%)
2,929,818	**3,249,630**	**319,812**	**9.8%**	**Total Administrative Expenses**	**28,485,765**	**32,116,939**	**3,631,174**	**11.3%**
(1,909,933)	**(873,382)**	**(1,036,551)**	**(118.7%)**	**Change in Net Assets**	**2,124,975**	**(10,146,462)**	**12,271,437**	**120.9%**
97.3%	***93.4%***	***3.8%***		***Medical Loss Ratio***	***91.3%***	***93.8%***	***(2.6%)***	
7.9%	***9.0%***	***1.1%***		***Admin Loss Ratio***	***8.1%***	***9.1%***	***0.9%***	

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ONECARE INCOME STATEMENT– APRIL MONTH:

REVENUES are $37.2 million, favorable to budget $1.0 million:

- Unfavorable volume related variance of $0.3 million
- Favorable price related variance of $1.3 million

MEDICAL EXPENSES are $36.2 million, unfavorable to budget $2.4 million:

- Favorable volume related variance of $0.3 million
- Unfavorable price related variance of $2.7 million due to Prescription Drug expenses

ADMINISTRATIVE EXPENSES are $2.9 million, favorable to budget $0.3 million

- Salaries, Wages & Employee Benefits expenses favorable to budget $0.2 million
- Non-Salary expenses favorable to budget $0.1 million

CHANGE IN NET ASSETS is ($1.9) million, unfavorable to budget $1.0 million

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
506	**490**	**16**	**3.3%**	**Member Months**	**5,035**	**4,789**	**246**	**5.1%**
				Revenues				
3,451,142	3,074,819	376,323	12.2%	Medi-Cal Capitation Revenue	33,234,202	30,070,259	3,163,943	10.5%
824,247	788,773	35,474	4.5%	Medicare Part C Revenue	8,210,517	7,461,220	749,297	10.0%
339,406	248,141	91,265	36.8%	Medicare Part D Revenue	3,196,268	2,411,372	784,896	32.5%
4,614,796	**4,111,733**	**503,063**	**12.2%**	**Total Operating Revenue**	**44,640,986**	**39,942,851**	**4,698,135**	**11.8%**
				Medical Expenses				
1,289,610	1,381,529	91,919	6.7%	Medical Management	12,701,608	13,654,215	952,607	7.0%
724,693	758,870	34,177	4.5%	Facilities Claims	6,833,388	7,456,774	623,386	8.4%
793,217	840,875	47,658	5.7%	Professional Claims	6,885,898	8,236,563	1,350,665	16.4%
639,240	567,390	(71,850)	(12.7%)	Prescription Drugs	5,871,337	5,506,216	(365,121)	(6.6%)
96,179	44,119	(52,060)	(118.0%)	MLTSS	194,226	315,555	121,329	38.4%
276,179	260,446	(15,733)	(6.0%)	Patient Transportation	2,404,210	2,604,469	200,259	7.7%
3,819,118	**3,853,229**	**34,111**	**0.9%**	**Total Medical Expenses**	**34,890,668**	**37,773,792**	**2,883,124**	**7.6%**
795,678	**258,504**	**537,174**	**207.8%**	**Gross Margin**	**9,750,318**	**2,169,059**	**7,581,259**	**349.5%**
				Administrative Expenses				
179,843	174,602	(5,241)	(3.0%)	Salaries, Wages & Employee Benefits	1,697,780	1,724,663	26,883	1.6%
2,292	8,708	6,416	73.7%	Professional Fees	59,760	87,380	27,620	31.6%
127,738	72,474	(55,264)	(76.3%)	Purchased Services	612,931	669,153	56,222	8.4%
22,179	10,530	(11,649)	(110.6%)	Printing & Postage	134,601	171,390	36,789	21.5%
991	1,600	609	38.1%	Depreciation & Amortization	9,720	16,000	6,280	39.2%
7,240	14,252	7,012	49.2%	Other Operating Expenses	92,947	131,717	38,770	29.4%
16,899	16,948	49	0.3%	Indirect Cost Allocation, Occupancy	176,053	167,030	(9,023)	(5.4%)
357,181	**299,114**	**(58,067)**	**(19.4%)**	**Total Administrative Expenses**	**2,783,792**	**2,967,333**	**183,541**	**6.2%**
438,497	**(40,610)**	**479,107**	**1,179.8%**	**Change in Net Assets**	**6,966,526**	**(798,274)**	**7,764,800**	**972.7%**
82.8%	***93.7%***	***(11.0%)***		***Medical Loss Ratio***	***78.2%***	***94.6%***	***(16.4%)***	
7.7%	***7.3%***	***(0.5%)***		***Admin Loss Ratio***	***6.2%***	***7.4%***	***1.2%***	

CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
538	**568**	**(30)**	**(5.3%)**	**Member Months**	**5,130**	**5,680**	**(550)**	**(9.7%)**
				Revenues				
244,677	253,517	(8,840)	(3.5%)	Revenue	2,343,275	2,535,170	(191,895)	(7.6%)
244,677	**253,517**	**(8,840)**	**(3.5%)**	**Total Operating Revenue**	**2,343,275**	**2,535,170**	**(191,895)**	**(7.6%)**
				Medical Expenses				
203,256	207,784	4,528	2.2%	Medical Management	1,875,344	2,077,840	202,496	9.7%
45,790	32,957	(12,833)	(38.9%)	Waiver Services	383,469	329,570	(53,899)	(16.4%)
203,256	207,784	4,528	2.2%	Total Medical Management	1,875,344	2,077,840	202,496	9.7%
45,790	32,957	(12,833)	(38.9%)	Total Waiver Services	383,469	329,570	(53,899)	(16.4%)
249,046	**240,741**	**(8,305)**	**(3.4%)**	**Total Program Expenses**	**2,258,813**	**2,407,410**	**148,597**	**6.2%**
(4,369)	**12,776**	**(17,145)**	**(134.2%)**	**Gross Margin**	**84,462**	**127,760**	**(43,298)**	**(33.9%)**
				Administrative Expenses				
108,533	110,194	1,661	1.5%	Salaries, Wages & Employee Benefits	1,027,176	1,088,034	60,858	5.6%
1,417	1,417	0	0.0%	Professional Fees	14,167	14,170	3	0.0%
5	-	(5)	(100.0%)	Purchased Services	42	-	(42)	(100.0%)
8,431	8,250	(181)	(2.2%)	Other Operating Expenses	77,952	82,500	4,548	5.5%
6,804	7,333	529	7.2%	Indirect Cost Allocation, Occupancy	74,140	73,330	(810)	(1.1%)
125,189	**127,194**	**2,005**	**1.6%**	**Total Administrative Expenses**	**1,193,476**	**1,258,034**	**64,558**	**5.1%**
(129,558)	**(114,418)**	**(15,140)**	**(13.2%)**	**Change in Net Assets**	**(1,109,014)**	**(1,130,274)**	**21,260**	**1.9%**
101.8%	***95.0%***	***6.8%***		***Medical Loss Ratio***	***96.4%***	***95.0%***	***1.4%***	
51.2%	***50.2%***	***(1.0%)***		***Admin Loss Ratio***	***50.9%***	***49.6%***	***(1.3%)***	

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CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Ten Months Ending April 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%	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 Ten Months Ending April 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				
81,818	916,666	834,849	91.1%	Professional Fees	207,719	3,666,664	3,458,945	94.3%
81,818	**916,666**	**834,849**	**91.1%**	**Total Administrative Expenses**	**207,719**	**3,666,664**	**3,458,945**	**94.3%**
				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%**
(81,818)	**(916,666)**	**834,849**	**91.1%**	**Change in Net Assets**	**(207,719)**	**(3,666,664)**	**3,458,945**	**94.3%**
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%***	

CalOptima Health
Building - 505 City Parkway
Statement of Revenues and Expenses
For the Ten Months Ending April 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				
79,222	22,905	(56,317)	(245.9%)	Purchased Services	522,508	229,050	(293,458)	(128.1%)
181,030	195,000	13,970	7.2%	Depreciation & Amortization	1,809,567	1,950,000	140,433	7.2%
23,371	26,654	3,283	12.3%	Insurance Expense	246,158	266,540	20,382	7.6%
137,405	181,186	43,781	24.2%	Repair & Maintenance	1,213,786	1,811,860	598,074	33.0%
46,424	56,824	10,400	18.3%	Other Operating Expenses	572,752	568,240	(4,512)	(0.8%)
(467,451)	(482,569)	(15,118)	(3.1%)	Indirect Cost Allocation, Occupancy	(4,364,772)	(4,825,690)	(460,918)	(9.6%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

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CalOptima Health
Building - 500 City Parkway
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
209,847	135,866	73,981	54.5%	Rental Income	1,617,657	1,358,660	258,997	19.1%
209,847	**135,866**	**73,981**	**54.5%**	**Total Operating Revenue**	**1,617,657**	**1,358,660**	**258,997**	**19.1%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
39,121	9,330	(29,791)	(319.3%)	Purchased Services	409,863	93,300	(316,563)	(339.3%)
58,789	51,000	(7,789)	(15.3%)	Depreciation & Amortization	550,551	510,000	(40,551)	(8.0%)
8,600	8,746	146	1.7%	Insurance Expense	82,901	87,460	4,559	5.2%
49,079	94,592	45,513	48.1%	Repair & Maintenance	439,577	945,920	506,343	53.5%
15,396	25,978	10,582	40.7%	Other Operating Expenses	237,591	259,780	22,189	8.5%
(18,107)	-	18,107	100.0%	Indirect Cost Allocation, Occupancy	(182,202)	-	182,202	100.0%
152,877	**189,646**	**36,769**	**19.4%**	**Total Administrative Expenses**	**1,538,281**	**1,896,460**	**358,179**	**18.9%**
56,971	**(53,780)**	**110,751**	**205.9%**	**Change in Net Assets**	**79,377**	**(537,800)**	**617,177**	**114.8%**

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CalOptima Health
Building - 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Ten Months Ending April 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%
55,433	42,500	(12,933)	(30.4%)	Purchased Services	302,239	425,000	122,761	28.9%
9,397	21,000	11,603	55.3%	Depreciation & Amortization	93,974	210,000	116,026	55.3%
4,751	-	(4,751)	(100.0%)	Insurance Expense	46,499	-	(46,499)	(100.0%)
298	-	(298)	(100.0%)	Repair & Maintenance	2,773	-	(2,773)	(100.0%)
905	-	(905)	(100.0%)	Other Operating Expenses	11,033	-	(11,033)	(100.0%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
70,784	**63,500**	**(7,284)**	**(11.5%)**	**Total Administrative Expenses**	**456,519**	**635,000**	**178,481**	**28.1%**
(70,784)	**(63,500)**	**(7,284)**	**(11.5%)**	**Change in Net Assets**	**(456,519)**	**(635,000)**	**178,481**	**28.1%**

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OTHER PROGRAM INCOME STATEMENTS – APRIL MONTH:

PACE

- **CHANGE IN NET ASSETS** is $0.4 million, favorable to budget $0.5 million

MSSP

- **CHANGE IN NET ASSETS** is ($129,558), unfavorable to budget $15,140

Covered CA

- **CHANGE IN NET ASSETS** is ($0.1) million, favorable to budget $0.8 million

NON-OPERATING INCOME STATEMENTS – APRIL MONTH:

BUILDING 500 City Parkway

- **CHANGE IN NET ASSETS** is $56,971, favorable to budget $110,751
  - Net of $209,847 in rental income and $152,877 in expenses

BUILDING 7900 Garden Grove Blvd

- **CHANGE IN NET ASSETS** is ($70,784), unfavorable to budget $7,284

INVESTMENT INCOME

- Favorable variance of $13.1 million due to $7.8 million of interest income and $5.3 million of realized and unrealized gain on investments

CalOptima Health
Balance Sheet
April 30, 2025

	April-25	March-25	$ Change	% Change
ASSETS				
Current Assets				
Cash and Cash Equivalents	647,124,850	895,404,584	(248,279,733)	(27.7%)
Short-term Investments	1,310,577,272	1,498,523,474	(187,946,202)	(12.5%)
Capitation Receivable	537,951,695	516,775,403	21,176,292	4.1%
Receivables - Other	87,624,913	82,991,379	4,633,534	5.6%
Prepaid Expenses	13,488,139	11,877,838	1,610,301	13.6%
Total Current Assets	**2,596,766,869**	**3,005,572,677**	**(408,805,808)**	**(13.6%)**
Board Designated Assets				
Board Designated Reserves	1,574,463,632	1,104,459,403	470,004,229	42.6%
Statutory Designated Reserves	131,577,245	130,340,221	1,237,024	0.9%
Total Board Designated Assets	**1,706,040,877**	**1,234,799,624**	**471,241,253**	**38.2%**
Restricted Deposit	**300,000**	**300,000**	**-**	**0.0%**
Capital Assets, Net	**100,263,668**	**100,302,441**	**(38,773)**	**(0.0%)**
Total Assets	**4,403,371,414**	**4,340,974,742**	**62,396,672**	**1.4%**
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	**4,479,270,421**	**4,416,873,749**	**62,396,672**	**1.4%**
LIABILITIES				
Current Liabilities				
Accounts Payable	105,118,422	231,222,085	(126,103,662)	(54.5%)
Medical Claims Liability	1,221,299,157	1,079,808,724	141,490,433	13.1%
Accrued Payroll Liabilities	25,847,041	23,965,355	1,881,687	7.9%
Deferred Revenue	14,468,620	10,890,083	3,578,537	32.9%
Other Current Liabilities	-	-	-	0.0%
Capitation & Withholds	150,387,620	143,284,377	7,103,244	5.0%
Total Current Liabilities	**1,517,120,861**	**1,489,170,623**	**27,950,238**	**1.9%**
GASB 96 Subscription Liabilities	17,058,702	18,048,802	(990,100)	(5.5%)
Community Reinvestment	147,803,571	142,933,596	4,869,974	3.4%
Capital Lease Payable	258,865	258,913	(48)	(0.0%)
Postemployment Health Care Plan	17,697,644	17,672,787	24,856	0.1%
Net Pension Liability	45,981,359	45,981,359	-	0.0%
Total Liabilities	**1,745,921,002**	**1,714,066,081**	**31,854,921**	**1.9%**
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	128,094,238	126,889,770	1,204,467	0.9%
Funds in excess of TNE	2,596,608,736	2,567,271,452	29,337,284	1.1%
Total Net Position	**2,724,702,974**	**2,694,161,223**	**30,541,751**	**1.1%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION	**4,479,270,421**	**4,416,873,749**	**62,396,672**	**1.4%**

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BALANCE SHEET – APRIL MONTH:

ASSETS of $4.5 billion increased $62.4 million from March or 1.4%

- Total Board Designated Assets increased $471.2 million due to a $460.0 million transfer from operating accounts, along with $10.0 million of net investment income
- Capitation Receivables increased $21.2 million due primarily to accrual for the QWI program for CY 2024 and 2025
- Operating Cash and Short-term Investments decreased $436.2 million due to a $460.0 million transfer to Tier One Board Designated accounts and $71.6 million for PM Private Hospital Directed Payments (PHDP), offset by receipts of $106.6 million for the Hospital Quality Assurance Fee (HQAF) program and current month investment income

LIABILITIES of $1.7 billion increased $31.9 million from March or 1.9%

- Total Claims Liabilities increased $141.5 million due to the timing of CY 2024 HQAF payments
- Accounts Payable decreased $126.1 million due primarily to the Managed Care Organization (MCO) tax payments
- Total Capitation and Withholds increased $7.1 million due to $6.0 million of monthly QWI accruals, along with $1.0 million for shared risk pool

NET ASSETS of $2.7 billion, increased $30.5 million from March or 1.1%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of April 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	787,603,202				
MetLife Tier One	786,860,430				
Board Designated Reserves	1,574,463,632	1,019,185,884	1,630,697,415	555,277,748	(56,233,783)
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	65,917,144				
MetLife Tier Two	65,660,101				
Statutory Designated Reserves	131,577,245	128,094,238	140,903,661	3,483,007	(9,326,417)
Current Reserve Level (X min. TNE) [1]	*1.03*	*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
April 30, 2025

	April 2025	July 2024 - April 2025
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	30,541,751	279,620,799
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation & Amortization	768,449	9,632,667
Changes in assets and liabilities:		
Prepaid expenses and other	(1,610,301)	(2,319,019)
Capitation receivable	(25,809,826)	(70,890,124)
Medical claims liability	141,490,433	69,455,032
Deferred revenue	3,578,537	(792,543)
Payable to health networks	7,103,244	(25,846,074)
Accounts payable	(126,103,662)	(67,201,184)
Accrued payroll	1,906,543	288,017
Other accrued liabilities	3,879,827	41,472,261
Net cash provided by/(used in) operating activities	35,744,994	233,419,832
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	187,946,202	467,318,668
Change in Property and Equipment	(729,676)	(13,335,528)
Change in Restricted Deposit & Other	-	-
Change in Board Designated Reserve	(471,241,253)	(568,277,439)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	(284,024,728)	(114,294,299)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	(248,279,733)	119,125,533
CASH AND CASH EQUIVALENTS, beginning of period	895,404,584	527,999,317
CASH AND CASH EQUIVALENTS, end of period	**647,124,850**	**647,124,850**

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CalOptima Health
Spending Plan
For the Ten Months Ending April 30, 2025

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 4/30/2025	**$2,724.7**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,574.5**			**57.8%**
	Statutory Designated Reserve[1]	**$131.6**			**4.8%**
	Capital Assets, net of Depreciation[2]	**$100.3**			**3.7%**
Resources Allocated[3]	Homeless Health Initiative[3]	$18.7	$66.0	$47.3	0.7%
	Housing and Homelessness Incentive Program[3]	21.9	87.4	65.5	0.8%
	Intergovernmental Transfers (IGT)	54.3	111.7	57.4	2.0%
	Digital Transformation and Workplace Modernization[4]	35.6	100.0	64.4	1.3%
	CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
	CalFresh and Redetermination Outreach Strategy	1.9	6.0	4.1	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	0.2	0.5	0.3	0.0%
	General Awareness Campaign	1.0	4.7	3.7	0.0%
	Member Health Needs Assessment	1.1	1.3	0.2	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	123.1	153.5	30.4	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)	17.6	18.0	0.4	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	6.1	107.5	101.4	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	3.6	7.6	4.0	0.1%
	Quality Initiatives from unearned Pay for Value Program	18.7	23.3	4.6	0.7%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.5	1.2	0.7	0.0%
	Medi-Cal Provider Rate Increases	350.8	526.2	175.4	12.9%
	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:	**$788.4**	**$1,422.5**	**$634.0**	**28.9%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$130.0**			**4.8%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 157 days of CalOptima Health's current operations.
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements.
[3] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.
[4] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

CalOptima Health
Key Financial Indicators
As of April 30, 2025

	Item Name	April 2025					July 2024 - April 2025				
		Actual	Budget	Variance	%		Actual	Budget	Variance	%	
Income Statement	Member Months	901,899	901,997	(98)	(0.0%)		9,115,951	9,008,279	107,672	1.2%	
	Operating Revenue	392,520,755	359,983,298	32,537,457	9.0%		4,260,164,958	3,572,238,549	687,926,409	19.3%	
	Medical Expenses	365,105,164	351,028,604	(14,076,560)	(4.0%)		3,931,330,778	3,545,190,357	(386,140,421)	(10.9%)	
	General and Administrative Expense	22,147,646	25,693,364	3,545,718	13.8%		209,524,864	247,197,069	37,672,205	15.2%	
	Non-Operating Income/(Loss)	25,273,805	5,370,555	19,903,250	370.6%		160,311,484	53,796,459	106,515,025	198.0%	
	Summary of Income & Expenses	30,541,751	(11,368,115)	41,909,866	368.7%		279,620,799	(166,344,418)	445,965,217	268.1%	

Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance		Actual	Budget	Variance	
	Consolidated	93.0%	97.5%	(4.5%)		92.3%	99.2%	(7.0%)	

	Administrative Loss Ratio (ALR)	Actual	Budget	Variance		Actual	Budget	Variance	
	Consolidated	5.6%	7.1%	1.5%		4.9%	6.9%	2.0%	

Key:

> 0%	
> -20%, < 0%	
< -20%	

Investment	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
	@4/30/2025	2,916,063,487	2,703,719,898	212,343,589	7.9%

	Unallocated/Unassigned Reserve Balance	Current Month @ April 2025	Fiscal Year Ending June 2024	Change	%
	Consolidated	129,965,006	187,643,914	(57,678,908)	(30.7%)
	*Days Cash On Hand**	157			

*Total Designated Reserves and unallocated reserve amount can support approximately 157 days of CalOptima Health's current operations.

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Ten Months Ending April 30, 2025

	April 2025				July 2024 - April 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	**1,030,586**	**1,041,246**	**10,660**	**1.0%**	**6,103,153**	**4,794,474**	**(1,308,679)**	**(27.3%)**	**14,546,013**	**28,858,183**	**14,312,170**	**49.6%**
Operating Expenses:												
Salaries, Wages & Benefits	548,047	589,848	41,801	7.1%	5,690,010	5,898,480	208,470	3.5%	16,696,277	16,904,747	208,470	1.2%
Professional Fees	(76,030)	543,986	620,016	114.0%	3,627,860	5,324,528	1,696,668	31.9%	5,388,922	7,085,590	1,696,668	23.9%
Purchased Services	305,386	142,000	(163,386)	(115.1%)	814,336	1,420,000	605,664	42.7%	964,337	1,570,000	605,664	38.6%
GASB 96 Amortization Expenses	51,082	293,417	242,335	82.6%	489,801	2,934,170	2,444,369	83.3%	2,461,004	4,905,373	2,444,369	49.8%
Other Expenses	610,587	726,777	116,190	16.0%	5,727,786	7,383,102	1,655,316	22.4%	19,257,278	20,912,594	1,655,316	7.9%
Medical Management	229,256	-	(229,256)	0.0%	2,292,565	-	(2,292,565)	0.0%	5,043,643	2,751,078	(2,292,565)	(83.3%)
Total Operating Expenses	**1,668,329**	**2,296,028**	**627,699**	**27.3%**	**18,642,359**	**22,960,280**	**4,317,921**	**18.8%**	**49,811,463**	**54,129,383**	**4,317,921**	**8.0%**

Funding Balance Tracking:	**Approved Budget**	**Actual Spend**	**Variance**
Beginning Funding Balance	100,000,000	100,000,000	-
Less:			
Capital Assets[1]	31,525,709	14,546,013	16,979,696
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	18,642,359	8,909,976
Ending Funding Balance	**9,752,853**	**35,642,525**	**25,889,672**
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 April 30, 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 & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	0
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	904,651	58,610
FQHC (Community Health Center) Expansion	21,902	21,902	0
HCAP and CalOptima Health Days	9,888,914	4,198,885	5,690,028
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine[1]	14,376,652	7,371,161	7,005,491
Outreach and Engagement	7,000,000	1,138,008	5,861,992
Housing and Homelessness Incentive Program (HHIP)[2]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$106,100,000**	**$47,271,655**	**$58,828,345**
Transfer of funds to HHIP[2]	(40,100,000)	-	(40,100,000)
Program Total	**$66,000,000**	**$47,271,655**	**$18,728,345**

Notes:

[1]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 to Healthcare in Action (Anaheim) and Celebrating Life Community Health Center (Costa Mesa).

[2]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 April 30, 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**	

Notes:
[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments.

CalOptima Health
Fiscal Year 2024-25 Budget Allocation Changes
Reporting Changes as of April 30, 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	$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

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $250,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors Meeting
June 5, 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 Department of Managed Health Care (DMHC) Routine Financial Examination:**

Update

- April 3, 2025 – Corrective Action Plan (CAP) response was submitted to DMHC.
- April 17, 2025 – DMHC issued Final Audit Report. DMHC found the compliance effort in the CAP response is responsive to the deficiency cited and no further action is required.
- April 29, 2025 – DMHC notification received that CAP is completed and audit is closed.

Previously Reported

- February 25, 2025 – DMHC issued Preliminary Findings Report.
  - One (1) deficiency noted related to the Plan's failure to timely file four (4) key personnel/management changes with DMHC. A CAP has been issued to the impacted operational area.
- CalOptima Health has 45 calendar days to review and respond to the Preliminary Findings Report.
- Pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act, the DMHC is responsible for conducting routine financial examinations of each health plan and issuing a public report for each plan.
- The purpose of the financial examinations is to evaluate and report on regulatory compliance with the Knox Keene Act. Each financial examination discusses plan performance in the areas of health plan fiscal and administrative functions.
- September 5, 2024 – the DMHC engaged CalOptima Health for the 2025 DMHC Routine Examination.
  - The examination will be of the Plan's fiscal and administrative affairs, including an examination of CalOptima Health's financial reports.
- January 31, 2025 – Audit sessions completed.

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b. **2025 Medicare Part C and Part D Data Validation Audit (MDVA) *(applicable to OneCare)***

Update

- Virtual audit sessions were held on April 1, 2025 and April 9, 2025.
- Source documentation and data file findings have been received for Coverage Determination & Redeterminations (CDR), Medication Therapy Management (MTM), Improving Drug Utilization Review Controls (IDURC), Part C/D Grievances and Organization Determinations & Reconsiderations (ODR). All of these measures have a data accuracy rate of 100%.
- As of April 28, 2025, source documentation for CDR, MTM and IDURC have been submitted to Advent.
- The source documentation for Part C/D Grievances and ODR are due to Advent by May 16, 2025.
- Pending data file results and source documentation request for Special Needs Plans (SNP) Care Management.

2. Medi-Cal

a. 2025 Department of Health Care Services (DHCS) Routine Medical Audit

Update

- 4/21/25: DHCS provided DRAFT findings reports to CalOptima Health.
- The DHCS Routine Medical Audit consists of DHCS's review of both the Primary (aka "Main Contract") and Secondary contracts (aka "State Supported Services"). The draft findings are as follows:

  - **Primary/Main Contract**
    - Draft Report Identified **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)**
    - Draft Report Identified **No Findings**

- **Exit Conference & Rebuttal Period:** DHCS hosted a virtual Exit Conference on 4/24/25 where they reviewed the draft findings report with CalOptima Health.
  - CalOptima Health will have 15 calendar days to provide feedback on the content of the draft report, if necessary. Feedback is due to DHCS on 5/9/25.

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- **Final Report & Corrective Action Plan (CAP):** DHCS will review CalOptima Health's feedback and finalize the draft report. The formal request for CAP will accompany the Final Report.
- **CAP Response:** Regulatory Affairs and Compliance (RAC) Medi-Cal anticipates that CalOptima Health will have thirty (30) calendar days from date of receipt, to respond to the formal CAP request.
- RAC Medi-Cal has met with the impacted business areas and confirmed remedial efforts are underway. RAC Medi-Cal anticipates a timely CAP submission.

Audit Details and Background

- October 23, 2024 – DHCS engaged CalOptima Health in its annual, routine medical audit.
  - The audit will consist 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 to be audited in this category:
        - Enhanced Care Management (ECM)
    - Availability and accessibility
    - Member's rights
    - Quality management
    - Administrative and organizational capacity
      - New area to be audited in this category:
        - Encounters
  - New areas to be audited
    - Enhanced Care Management (ECM)
    - Encounters
  - The audit is considered a limited-scope audit and requires the participation of two (2) CalOptima Health Networks: Children's Hospital of Orange County Health Alliance (CHOC) and Optum for UM only
  - Onsite interviews will be 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 will involve 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

- CalOptima Health did not receive any notices of non-compliance from its regulators for the month of April 2025.

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C. Updates on Health Network Monitoring and Audits

a. Health Network Audits

- None conducted in April and May 2025.

D. Internal Audit Department (IAD)

a. Internal Annual Audits in Progress

- 2024 Behavioral Health (BH) (Medi-Cal)
- 2025 Access & Availability (Medi-Cal)
- 2025 Customer Service (Medi-Cal)
- 2025 Customer Service (OneCare)
- 2025 Case Management (Medi-Cal)

b. Internal Annual Audits Completed

- 2024 Utilization Management (OneCare)- closed on 4/16/25
- 2024 Grievance & Appeals Resolution (CDAG-OneCare)- closed on 4/24/25

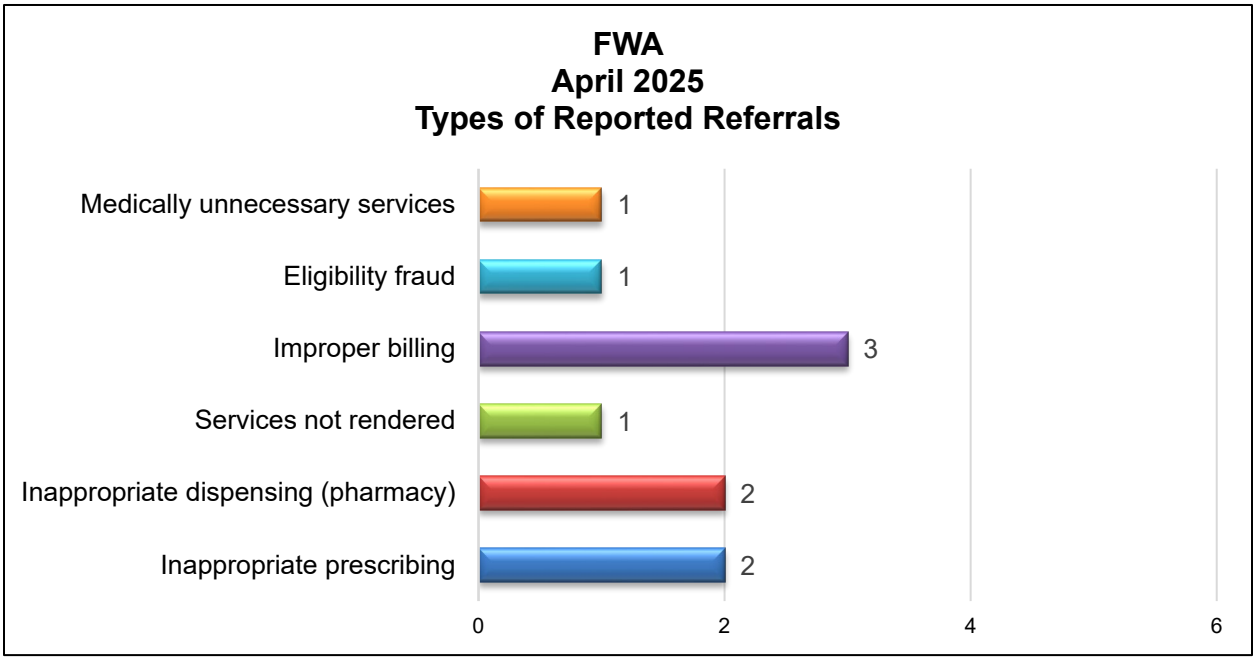
c. Board-Approved Grants and Initiatives Review

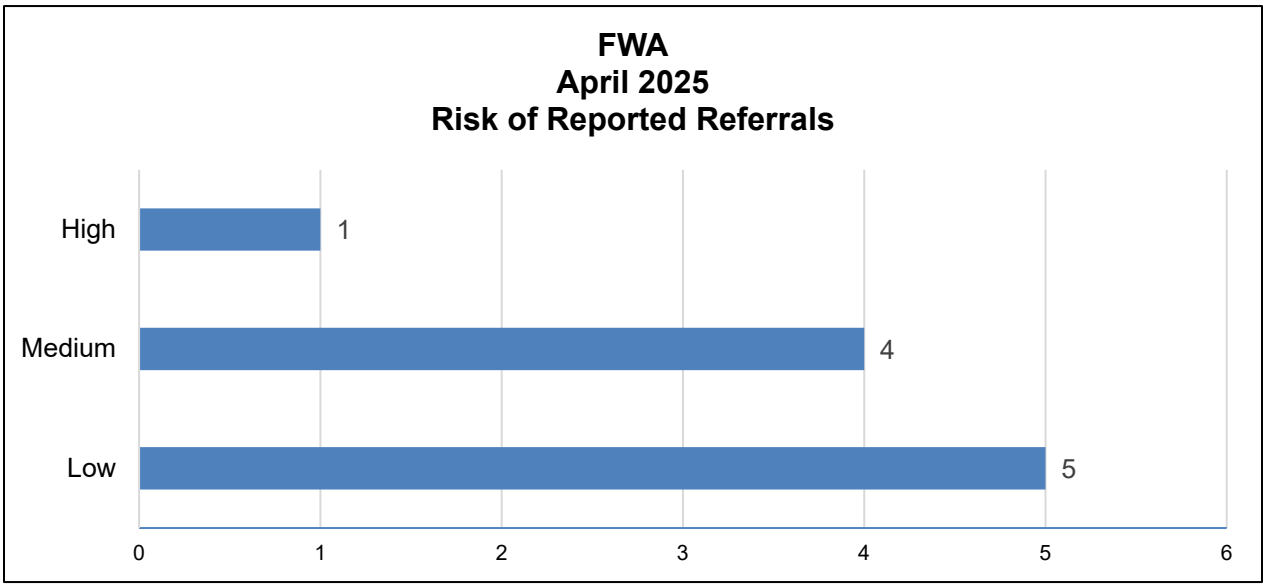
Grants currently under review include:

- Be Well/Mind OC, Irvine
  - Grant is in process. Review will resume upon close of grant in May-June 2025.
- Housing for Health Orange County
  - Grant is closed. Review scheduling TBD.
- Talbert Medical Group dba Optum
  - Grant is closed. Review scheduling TBD.

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E. Fraud, Waste & Abuse (FWA) Investigations

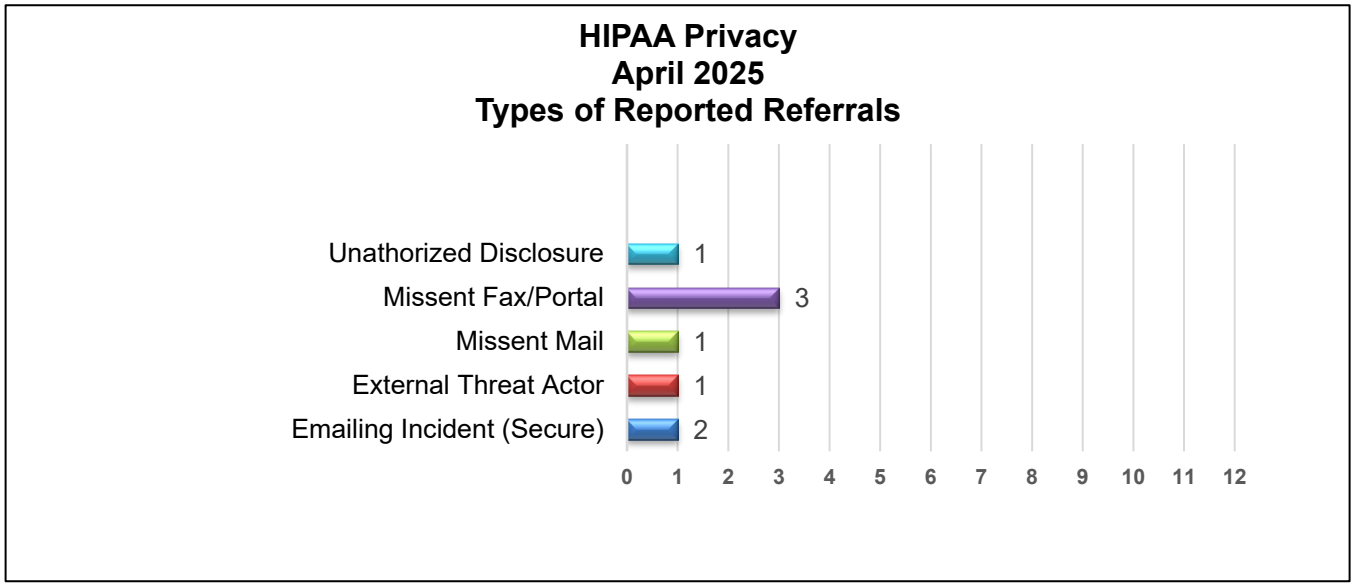


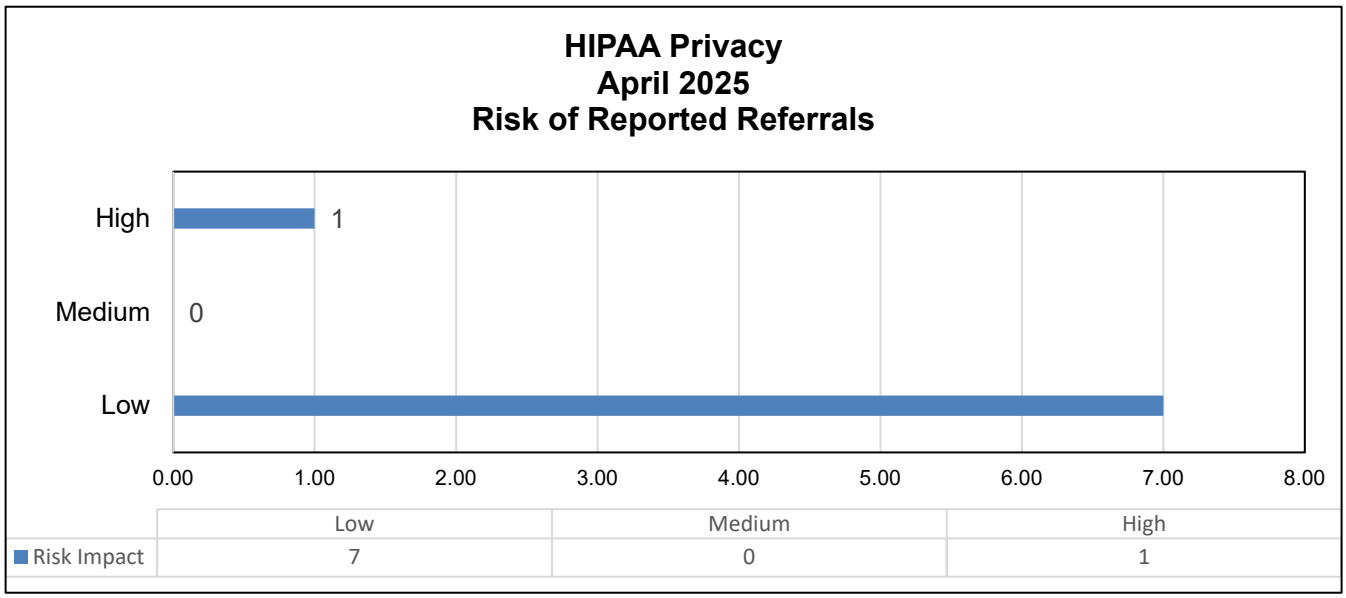


Total Number of New Cases Referred to DHCS (State)	10
Total Number of New Cases Referred to DHCS and CMS	6
Total Number of Referrals Reported	**10**

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F. Privacy Update





Total Number of Referrals Reported to DHCS (State)	8
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

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CHAMBER HILL

MEMORANDUM

TO: CalOptima Health
Board of Directors

FROM: Chamber Hill Strategies

DATE: May 28, 2025

SUBJECT: Board of Directors Report – June 2025

Delegation Outreach Continues, Meeting with Rep. Kim's Office in Advance of Vote

CalOptima Health and Chamber Hill Strategies (CHS) continue to be in contact with offices representing Orange County in Congress. In May, CalOptima Health and CHS were in contact with the Orange County congressional delegation about CalOptima Health and concerns 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). Beyond more traditional outreach, CalOptima Health and CHS met with staff to Rep. Kim in advance of House consideration of the budget reconciliation package (H.R. 1), outlining areas of concern—particularly as it relates the additional administrative burden that proposed policy changes could impose on Medicaid plans and state and local entities should they be enacted.

Outreach beyond Orange County Continues

CHS and CalOptima Health have continued to reach beyond Orange County to highlight the importance of supporting Medicaid for CalOptima Health's members and for California. As a follow-up to strategic meetings in Washington, D.C. on April 28, 29, and 30, advocacy continued both inside and outside Orange County, including leadership and those serving on key committees with health policy jurisdiction. Beyond California's U.S. Senators and the Orange County delegation in Congress, follow-up outreach included the following offices:

- Representative Jay Obernolte (R-CA-23), member, House Committee on Energy & Commerce, Subcommittee on Health, which has House oversight of Medicaid and Medicare policy; member, House Committee on the Budget.

- Representative Ken Calvert (R-CA-41), member, House Committee on Appropriations; Chair, House Appropriations Subcommittee on Defense; most senior and highest-ranking California Republican in Congress.
- Representative David Valadao (R-CA-22), member, House Committee on the Budget; leader of letter from 12 Republican representatives to House Republican leadership expressing support for Medicaid and concerns about impact of Medicaid cuts.
- Representative Kevin Kiley (R-CA-3), member, Republican Study Committee, conservative Republican organization.
- Representative Tom McClintock (R-CA-5), member, House Committee on the Budget.
- Representative Pete Aguilar (D-CA-33), Chair, House Democratic Caucus, and highest-ranking California member in congressional leadership.
- Representative Raul Ruiz, MD (D-CA-25), member, House Committee on Energy & Commerce, Subcommittee on Health.
- Senator Bill Cassidy, MD (R-LA), Chair, Senate Committee on Health, Labor, & Pensions (HELP); member, Senate Committee on Finance, which has Senate oversight of Medicaid and Medicare policy. Sen. Cassidy is widely regarded as a leader in health policy.
- House GOP Doctors Caucus—Co-chaired by Representatives Greg Murphy, MD (R-NC-3) and John Joyce, MD (R-PA-13), the Caucus is an organization of Republican physicians, dentists, and other health care professionals in Congress and plays a significant role in the House Republican Conference on health policy; the current membership is 14 but varies depending on number of elected health professionals in Congress.

House Approves Budget Reconciliation Bill, Senate Consideration Up Next

On May 22, the U.S. House of Representatives in a 215-214 vote passed the "One Big Beautiful Bill Act" (H.R. 1). All 212 Democrats were joined by 2 Republicans in voting against passage. One Republican voted "Present," which ensured the majority of voting members needed for the legislation to clear the House and go to the Senate. House approval followed numerous committee meetings in the weeks leading up, and negotiations involving House leadership, the White House, and factions of moderates and the more conservative House Freedom Caucus (HFC) continued leading up to passage all the way up to the night of May 21, the night before the House approved H.R. 1. The legislation includes several health-related provisions, with a particular focus on Medicaid, including, but not limited to, the following:

- Medicaid Eligibility Determination – Increase eligibility determinations for expansion population to every 6 months;
- Penalties for Medicaid Coverage of Immigrants without Legal Status – Reduce FMAP by 10% for states providing Medicaid to undocumented immigrants;
- Provider Tax Moratorium – Freeze state provider taxes in effect and prohibit states from establishing new provider taxes to fund Medicaid;
- Medicaid Work Requirement – Require able-bodied adults without dependents to work 80 hours/month—could also include community service and educational programs;
- Cost Sharing Requirements – Require states to impose cost sharing on Medicaid expansion adults at over 100% of FPL—exception for primary, prenatal, pediatric, and emergency care; and

- Changes to Advance Premium Tax Credits for Coverage (APTCs) – Require pre-verification of eligibility for APTCs and end passive enrollment in marketplace coverage.

The budget resolution (H. Con. Res. 14) approved by both chambers called for the House Energy & Commerce Committee to produce $880 billion in savings, and as expected, Medicaid accounted for a significant portion of these dollars—with more than $700 billion in savings estimated to come from Medicaid. In the lead up to a House vote, HFC holdouts pushed for changes to the FMAP, provider taxes, and Medicaid work requirements. While moderates were successful in staving off changes to the FMAP and provider tax provisions, the negotiated package passed by the House did move up the effective dates of the eligibility determination and work requirement provisions to December 31, 2026 from October 1, 2027 and January 1, 2029, respectively, which had been included an earlier version of the legislation previously approved by the House Energy & Commerce Committee during the week of May 12.

With House approval of H.R. 1, the bill will now go to the Senate for consideration. Senate Majority Leader John Thune (R-SD) has yet to release a plan for Senate consideration, but he has indicated his desire to have the Senate complete its process in time for the House to approve any Senate changes and send it to President Trump for signature before July 4. Initial reports had President Trump and Speaker of the House Mike Johnson (R-LA) making comments urging the Senate to limit changes to the House-passed bill that has captured the input of a wide range of House perspectives, but the President has now seemed to back off those comments and encourage the Senate to make the changes it deems appropriate. If a bill is to get to the White House by July 4, we can expect a flurry of activity in June as lawmakers work to further refine the bill's provisions to yield a package that accounts for the varying priorities of the House and Senate.

CalOptima Health Outlines Concerns in Letter to Rep. Kim

CalOptima Health sent a May 20 letter to Representative Young Kim (R-CA-40) responding to provisions in the "One Big Beautiful Bill Act" (H.R. 1). The letter was signed by CalOptima Health Chief Executive Officer (CEO) Michael Hunn and highlights areas of concern, including implementation of the work requirement, cost-sharing for the Medicaid population, provider taxes, and the FMAP penalty for covering certain immigrants. The letter has also been shared with California's U.S. Senators and the broader Orange County delegation.

White House Releases Budget Blueprint, Outlining Priorities

On May 2, the White House released a broad budget framework, referred to as a "skinny" budget, outlining its discretionary spending priorities for Fiscal Year 2026. The budget, which is nonbinding, would request Health & Human Services (HHS) funding at $93.8 billion, a 26.2% decrease f rom FY2025. In focusing on discretionary spending, the request would not impact Medicaid or Medicare benefits. The budget does provide insights into the new Administration for a Healthy America (AHA). The budget also allocates $500 million for the Make America Healthy Again (MAHA) initiative and would seek to provide resources to the HHS Secretary to address issues related to nutrition, physical activity, healthy lifestyles, over-reliance on medication and treatments, the effects of new technological

habits, environmental impacts, food and drug quality and safety. Also of note, the budget announcement stated it would support the creation of MAHA food boxes, which would be filled with products from domestic farms and be given directly to American households. While a date for its release has not been specified, a more detailed budget is expected from the White House in the coming weeks.

Congress Hears from HHS Secretary on FY26 Budget

Following the release of the skinny budget, HHS Secretary Robert F. Kennedy, Jr. testified before three separate congressional panels in May on the Administration's HHS budget request for Fiscal Year 2026 (FY26). On May 14, the Secretary appeared before the House Appropriations Committee's Subcommittee on Labor, Health & Human Services, Education, and Related Agencies and before the Senate Health, Education, Labor & Pensions (HELP) Committee; and on May 20, the Secretary appeared before the Senate Appropriations Subcommittee on Labor, Health & Human Services, Education, and Related Agencies. Secretary Kennedy used the hearings to outline how the budget request aims to help HHS meet its goals of reducing the high rates of chronic disease and delivering services in the most efficient way possible. Republicans generally applauded the Secretary for focusing on trying to reduce the high rates of chronic disease and on making HHS more efficient. Democrats expressed concerns about the impact of reductions in the workforce at HHS, the impounding or freezing of already appropriated congressional funds, and the proposed cuts and reorganization within HHS outlined in the FY 26 skinny budget request. Democrats also used the hearings to raise concerns about Medicaid cuts being proposed under the budget reconciliation process.

CMS Issues Proposal to Roll Back Provider Taxes

On May 12, CMS announced a proposed rule targeting state provider taxes on managed care organizations (MCOs). The proposed rule would require uniformity between MCO tax rates that are imposed on Medicaid and non-Medicaid lines of business. In its press release, CMS called MCO taxes a "Medicaid tax loophole" that states use to free up funds for non-Medicaid purposes and to provide benefits to undocumented immigrants. In announcing the rule, CMS also noted the Biden administration's approval of four MCO tax waivers for California, Michigan, Massachusetts, and New York in its final year. CMS projects the proposed rule would yield federal savings of $30 billion over 5 years. The proposed rule is open for comment until July 14, 2025.

Administration Releases Make America Healthy Again Report

On May 22, the Make America Healthy Again (MAHA) Commission released the anticipated MAHA Report, which examines the drivers of chronic childhood disease, including potential factors such as poor diet, lack of physical activity, and overprescribing of medications. In announcing the report, the Administration stated that the next steps will include supporting research and developing a strategy to address chronic childhood disease. The effort will be a collaborative effort including the National Institutes of Health, the Food and Drug Administration, and CMS. In commenting on the report's release, HHS Secretary Robert F. Kennedy, Jr. stated there is currently no budget to implement the MAHA agenda as the Administration will be working on specific policy recommendations over the next 100 days.

President Announces New Nominee for Surgeon General

On May 7, President Donald J. Trump announced the nomination of Casey Means, MD to the role of U.S. Surgeon General. Dr. Means's nomination came after the withdrawal of Janette Nesheiwat, MD, which followed revelations about misrepresentation of her medical education. Dr. Means is viewed as being aligned with HHS Secretary Kennedy and has expressed similar concerns and views about the rising rates of chronic disease in the United States.

CALOPTIMA HEALTH - STATE LEGISLATIVE REPORT
May 27, 2025

General Update

The mood in the Capitol continues to be grim. Various interest groups advocating for continued funding bombard legislative offices, hallways and hearing rooms. Lines often wrap around the building causing a 45-minute wait to enter; to then be greeted with an elevator line.

With the Revised Budget dropping a reality check on May 14, most legislators have never dealt with state budget deficits and are just now grappling with the looming fiscal challenges. However, at the May 23rd Appropriations Suspense Hearings, a place where spending bills often die, bills were released at the typical pace of previous years. The Assembly released 435 bills off the suspense file for a floor vote representing a 65% passage rate - the same as last year. The Senate passed 307 measures off the suspense file representing a 71% passage rate - about 4% less than last year.

The next critical deadline is June 15 when the legislature must return a budget to the Governor.

Budget Update

The Governor released his Revised Budget on May 14. The budget deterioration from a balanced budget in January to a large May deficit is the result of two key factors: a $5 billion revenue decrease and an unusually high increase in spending, most notably in Medi-Cal. The Administration attributes a significant share of Medi-Cal growth to individuals lacking satisfactory immigration status.

The Governor's proposal to address the deficit has a substantial impact on Medi-Cal and does not include the use of additional reserves. This has caused harsh legislative rebukes in early budget hearings, particularly related to the coverage cuts to the undocumented. Key budget points:

FY 2025-26 State Budget	
Total Budget	*$322 billion*
General Fund	*$226 billion*
Shortfall	*$12 billion*
Reserves	*$16 billion*

Medi-Cal Savings in FY 2025-26 State Budget

- *Freeze new enrollment of undocumented adults 19+*
- *Instate $100 monthly premiums and cuts to long-term care and dental benefits for current undocumented adults 19+*
- *Scale back prescription access to GLP-1s*
- *Reinstate asset limit for seniors*
- *Borrow billions from special funds (Prop 35) intended to raise reimbursement rates for Medi-Cal providers*

The California Latino Legislative Caucus, which has made continuing Medi-Cal coverage for undocumented persons a top priority, is vigorously pushing back on the proposed Medi-Cal cuts. At a press conference, Senate Health Committee Chair Caroline Menjivar-D (San Fernando Valley) stated that the Governor's proposal looks like it came from "a Republican, perhaps in Alabama."

The Administration has encouraged the legislature to provide alternatives, stating the revised budget attempts to rein in spending that will continue to grow the deficit through the next few budget cycles. Spirited debates will occur over the next month as the legislature struggles to identify funding to replace the Governor's proposals with their own priorities.

The May Revise does not include the anticipated cuts in Medicaid at the federal level. Because of federal budget uncertainty, the legislature is planning to formally revisit the state budget in the fall.

PACE Proposed Changes – One concerning surprise in the May Revise was a proposal to freeze payments to PACE organizations at no greater than the midpoint of the actuarial rate range beginning January 2026. This represents an annual rate cut of $60 million to PACE programs *in addition to* the previous budget change proposal/trailer bill language which represented $20 million in new fees imposed on PACE programs.

CalPACE, the association representing PACE programs statewide, is in active opposition to these projected $80 million in losses to PACE programs. CalOptima Health has joined other PACE programs in a coalition letter opposing these proposals.

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, including off the premises of the provider's site. Passing unanimously in the Assembly Appropriations Committee, the bill will now go to the Assembly Floor. The bill sponsor has preliminarily agreed to an amendment by the Local Health Plans of California (LHPC) requiring providers to contract with plans.

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 out of the Assembly Appropriations Committee on May 23 with no opposition. It will now head to the Assembly Floor before heading to the upper house.

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 Appropriations Committee on May 23 with no opposition and will head to the Senate Floor.

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 the Senate Appropriations Committee on May 23 and will head to the Senate Floor.

Other Program Updates

Behavioral Health Transformation (BHT) (Proposition 1) – DHCS announced the award of $3.3 billion in grants on May 12 for Round 1 (Launch Ready) of the Behavioral Health Continuum Infrastructure Program (BHCIP). One project in Orange County was awarded a grant, a 50-bed perinatal residential SUD facility in Costa Mesa.

The Round 2 (Unmet Needs) solicitation for $1.1 billion in funding is imminent and will be awarded by 2026.

California's Essential Health Benefits (EHB) – (now SB 62 (Menjivar-D)) – A legislative joint hearing was held in February to review possible additions to California's EHBs, which have not changed since 2012. Proposed coverage expansion includes fertility treatments (including in-vitro fertilization); annual hearing exams and hearing aids; and mobility devices (walkers, wheelchairs and scooters). The EHB benchmark plan was then put into SB 62 to codify the proposed changes in advance of the application submittal to CMS on May 5. The effective date of the new plan, if approved, is January 2027.

In the Senate Health Committee hearing, some senators expressed concern about these EHBs being statutorily mandated once CMS approves the application. The application approval could happen before California is aware of the anticipated federal cuts to Medicaid, taking away the State's flexibility in making changes. Despite this concern, the bill passed the Senate Health Committee on May 12 and the Senate Appropriations Committee on May 23.

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.	**03/25/2025** Passed Senate Public Safety Committee; referred to Senate Appropriations Committee	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.	**04/30/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee	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.	**04/30/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee	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.	**04/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	**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.	**05/07/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Budget			
H.R. 1 Arrington (TX)	**One Big Beautiful Bill Act:** Would make 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 • Increased frequency of eligibility redeterminations for Medicaid Expansion (MCE) enrollees from annually to every six months, effective December 31, 2026 • State penalty for coverage of undocumented immigrants by decreasing the Federal Medical Assistance Percentage (FMAP) for MCE enrollees from 90% to 80%, effective October 1, 2027 • 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.	**05/22/2025** Passed House floor; referred to Senate	**05/20/2025** CalOptima Health: OPPOSE
SB 65 Weiner	**Budget Act of 2025:** Would make appropriations for the government of the State of California for the FY 2025–26 in alignment with the governor's proposed budget released on January 10, 2025. ***Potential CalOptima Health Impact*:** Adjusted but broadly sustained funding for programs impacting members.	**01/10/2025** Introduced	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
RN 25 12598 Trailer Bill Language	**Program of All-Inclusive Care for the Elderly (PACE) Fees:** Would assess an annual fee on PACE organizations in an amount up to one percent of annual capitation payments in order to fund the cost of DHCS operations and staffing related to PACE administration. ***Potential CalOptima Health Impact:*** Increased PACE administrative costs for CalOptima Health.	**03/24/2025** Published by the California Department of Finance	CalOptima Health: Watch CalPACE: Oppose
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.	**04/02/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch CAHP: Watch LHPC: Oppose
AB 543 Gonzalez	**Street Medicine:** Would integrate street medicine services for homeless individuals under Medi-Cal, mandating presumptive eligibility for full Medi-Cal benefits for homeless persons and authorizing any enrolled provider to determine eligibility. Would also require plans to allow homeless beneficiaries to access services from any provider outside traditional sites. Additionally, would require systems for beneficiaries to inform plans of their homeless status and mandate data sharing between Medi-Cal and the California Statewide Automated Welfare System (CalSAWS). ***Potential CalOptima Health Impact*:** Decreased service coordination and oversight related to street medicine providers.	**04/22/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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 not require a health plan to cover all types of insulin without step therapy, if at least one insulin in each drug type is covered 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.	**04/02/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee	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.	**04/30/2025** SB 62 passed Senate Health Committee; referred to Senate Appropriations Committee **04/29/2025** AB 224 passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Concerns
SB 535 Richardson **AB 575** Arambula	**Obesity Prevention Treatment and Parity 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 intensive behavioral therapy for the treatment of obesity without prior authorization. ***Potential CalOptima Health Impact:*** Expanded covered benefits for future members enrolled in Covered California line of business.	**04/30/2025** SB 535 passed Senate Health Committee; referred to Senate Appropriations Committee **02/24/2025** AB 575 referred to Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
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

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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.	**04/22/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
AB 432 Bauer-Kahan	**Menopause:** Would require a health plan to provide coverage for evaluation and treatment options for 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.	**04/29/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **04/22/2025** Passed Assembly Business and Professions Committee	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.	**04/08/2025** Passed Senate Judiciary Committee; referred to Senate Appropriations Committee **03/26/2025** Passed Senate Health Committee	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.	**04/29/2025** Passed Senate Public Safety Committee; referred to Senate Appropriations Committee **04/08/2025** Passed Senate Judiciary Committee	CalOptima Health: Watch
SB 530 Richardson	**Medi-Cal Time and Distance Standards:** Would extend current Medi-Cal time and distance standards indefinitely. 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. 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.	**04/09/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee	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.	**04/30/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee	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.	**04/29/2025** Passed Assembly Judiciary Committee; referred to Assembly Appropriations Committee **04/22/2025** Passed Assembly Privacy and Consumer Protection Committee	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.	**04/29/2025** Passed Assembly Judiciary Committee; referred to Assembly Appropriatons Committee **04/22/2025** Passed Assembly Health Committee	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. Would additionally 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.	**03/25/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 894 Carrillo	**Immigration and Patient Privacy:** Would state the intent of the Legislature to enact legislation protecting the privacy of undocumented Californians. ***Potential CalOptima Health Impact:*** Increased protection of medical information; increased staff training regarding disclosure processes.	**05/14/2025** Passed Assembly Appropriations Committee; referred to Assembly floor **04/22/2025** Passed Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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
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
AB 960 Garcia	**Dementia Patient Visitation:** Would require a health facility to allow a patient with demonstrated dementia needs to have a family or friend caregiver with them as needed. ***Potential CalOptima Health Impact:*** New visitation policies for PACE center.	**04/22/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	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.	**04/30/2025** Passed Senate Health Committee; referred to Senate Appropriatons Committee	CalOptima Health: Watch LHPC: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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.	**03/26/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch
SB 306 Becker	**Prior Authorization Exemption:** Would restrict health plans or their delegated entities from requiring prior authorization or prior notification for a covered health care service if 90% or more requests for that service were approved in the previous year. Would also require a health plan to post lists of covered health care services that are exempted from or subject to prior authorization on its website by March 15 of each year. ***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.	**04/23/2025** Passed Senate Health Committee; referred to Senate Appropriatons Committee	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

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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
AB 220 Jackson	**Medi-Cal Subacute Care Authorization:** Would mandate health facilities providing pediatric or adult subacute care to include a specific DHCS form with treatment authorization requests, preventing Medi-Cal MCPs from creating their own criteria for determining medical necessity outside of those specified in the form. Would allow DHCS to impose sanctions on non-compliant Medi-Cal MCPs. ***Potential CalOptima Health Impact:*** Modified UM procedures and forms.	**04/22/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	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. ***Potential CalOptima Health Impact:*** Increased oversight of CalOptima Health provider directory; increased coordination with contracted providers; increased penalty payments to DHCS.	**04/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
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 48 hours for standard requests or 24 hours for urgent 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.	**04/22/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	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. In addition, would require DMHC to establish minimum standards or policies and processes to streamline and reduce redundancy and delay in provider credentialing. Additionally, would require health plans to use a standardized credentialing form on and after July 1, 2027, or six months after the form is completed, whichever is later, with updates to the forms every three years thereafter. ***Potential CalOptima Health Impact:*** Expedited and modified credentialing procedures for interested providers.	**04/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
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
CalPACE: California PACE Association
LHPC: Local Health Plans of California

Last Updated: May 21, 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 — May and June 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

CalOptima Health partnered with Alinea Medical Imaging and Northgate Gonzalez Market to host a Breast Cancer Screening Mammogram Event at a store location in the city of Anaheim, where a high percentage of members are due for a mammogram. The event took place on Friday, May 30, from 9 a.m. to 4 p.m., and served CalOptima Health members enrolled in CCN and community members in the surrounding area. This helped reinforce our commitment to health, equity and access for all.

CalOptima Health's Equity and Community Health and Community Relations teams played a pivotal role in the event by providing blood pressure screenings, education on nutrition and women's health and disseminating information about CalOptima Health and Medi-Cal programs and services. Members who completed a mammogram received the $25 Member Health reward and community members received a $25 Northgate gift card.

Summary of Public Activities

As of May 7, CalOptima Health plans to participate in, organize or convene 89 public activities in May and June. There were 59 public activities in May, including 15 virtual community/collaborative meetings, 35 community events, eight community-based presentations and one Health Network Forum. In June, there will be 30 public activities, including 14 virtual community/collaborative meetings, 13 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 three 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 the Multi-Ethnic Collaborative of Community Agencies (MECCA) and their proposal for the Guaranteed Income (GI) Pilot Program for Older Adults.

2. Letter of support for HealthRIGHT 360's application for the California Department of Health Care Services' Capacity and Infrastructure Transition, Expansion, and Development (CITED) Initiative Round 4.

3. Letter of support for Community Action Partnership of Orange County (CAP OC) 2025 County Supportive Housing NOFA Submittal.

For additional information or questions, contact CalOptima Health Community Relations Director Tiffany Kaaiakamanu at 714-222-0637 or tkaaiakamanu@caloptima.org.

Attachment to the June 5, 2025 CalOptima Health Outreach Summary

Community events hosted by CalOptima Health and community partners in May and June 2025:

May 2025

May 1, 2:30–3:30 p.m., CalOptima Health Medi-Cal Overview in English and Spanish

Rio Vista Elementary School, 310 N. Rio Vista St., Anaheim

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

May 1, 5:30–7 p.m., Open House, hosted by Agnes Ware Stanley Elementary

Agnes Ware Stanley Elementary, 12201 Elmwood St., Garden Grove

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 1, 4–5:20 p.m., Choose Wellness Resource Fair, hosted by Garden Grove Unified School District

Fitz Intermediate Language Academy, 4600 W. McFadden St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 1, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Chippewa/ Greenleaf Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 2, 4–7 p.m., Festival de Los Niños, hosted by Advocates for Language Learning

Gates Elementary School, 23882 Landisview Ave., Lake Forest

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 3, 10 a.m.–1 p.m., Mental Health Community Resource Fair, hosted by the Villages of California

Betsy Ross Elementary School, 535 S. Walnut St., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 3, 9 a.m.–1 p.m., Health Fair, hosted by California State University Fullerton

Richman Park, 711 Highland Ave., Fullerton

- 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

May 3, 9 a.m.–2 p.m., Man(n)y Celebration, hosted by Asian American Senior Citizens Services Center

Heritage Museum of Orange County, 3101 W. Harvard St., Santa Ana

- Sponsorship fee: $500; included a resource table, organization name and logo on event flyer and website and social media mention of organization.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 3, 10 a.m.–2 p.m., Wellness Fair and Boutique, hosted by the Downtown Anaheim Community Center

Downtown Anaheim Community Center, 250 E. Center St., Santa Ana

- Registration fee: $150; included a resource table.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 3, 9 a.m.–Noon, Know More Do Better for Healthcare Providers, hosted by the Orange County Human Trafficking Task Force

The Salvation Army Tustin Ranch Corps, 10200 Pioneer Rd., Tustin

- Sponsorship fee: $500; included a resource table and use of organization logo.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 3, 9 a.m.–Noon, Grand Opening and Resource Fair, hosted by Share Ourselves

Share Ourselves at Costa Mesa, 1550 Superior Ave., Costa Mesa

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 4, 10:30 a.m.–1:30 p.m., Mental Health Resources Fair, hosted by the Second Baptist Church

Second Baptist Church, 4300 Westminster Ave., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 6, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Balsam/Curtis Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 7, 11:30 a.m.–1:30 p.m., Health and Wellness Fair, hosted by Cypress College

Cypress College, 9200 Valley View St., Cypress

- 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

May 7, 10:30–11:45 a.m., CalOptima Health Medi-Cal Overview in English
Olive Crest, 2130 E. 4th St., Santa Ana

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

May 7, 6–7 p.m., CalOptima Health Medi-Cal Overview in Spanish
Girl Scouts of Orange County, 407 E. 1st St., Santa Ana

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

May 8, 1–4 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services
Danbrook/Olinda Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 8, 4–6:30 p.m., Tiger Fest Open House, hosted by W.R. Nelson Elementary School
W. R. Nelson Elementary School, 14392 Browning Ave., Tustin

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 9, 1–3:30 p.m., College and Career Resource Fair, hosted by the Orange County Department of Education
Harbor Learning Center, 1240 N. Harbor Blvd., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 10, 11 a.m.–3 p.m., Hyo Festival, hosted by the Korean American Seniors Association of Orange County
Buena Park Community Center, 8150 Knott Ave., Buena Park

- Sponsorship fee: $1,000; included a resource table and full-page color ad in event booklet.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 10, 10 a.m.–2 p.m., Teen and Adult Resource Fair, hosted by TACA
Anaheim First Church of the Nazarene, 1340 N. Candlewood St., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 13, 10–10:30 a.m., CalOptima Health Medi-Cal Overview in English
The Village Community Room, 1505 E. 17th St., Santa Ana

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

May 14, 11 a.m.–Noon, CalOptima Health Medi-Cal Overview in English

Wellness Center West, 11277 Garden Grove Blvd. #101A, Garden Grove

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

May 14, 10 a.m.–3 p.m., 2025 Employee Health and Wellness Fair, hosted by North Orange County Community College Education

Cypress College, 9200 Valley View St., Cypress

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 14, 5:30–7 p.m., CalOptima Health Medi-Cal Overview in Spanish

El Modena Family Resource Center, 18672 E. Center Ave., Orange

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

May 15, 1–4 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Glen/Neighbors Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 17, 11:30 a.m.–2 p.m., Mental Health Awareness Family Event and Resource Fair, hosted by Olive Crest

Santa Ana Zoo, 1801 E. Chestnut St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 17, 11 a.m.–3 p.m., Family Wellness Day, hosted by the Boys and Girls Club of Garden Grove

Boys and Girls Club of Garden Grove, 9860 Larson Ave., Garden Grove

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 17, 12–5 p.m., Cruising for Education, hosted by Project Rise

Santa Ana College, 1530 W. 17th St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 20, 8 a.m.–4 p.m., 2025 FaCT Conference, hosted by Families and Communities Together Orange County

Hilton Costa Mesa, 3050 Bristol St., Costa Mesa

- Sponsorship fee: $15,000; included 15 tickets, top logo placement on all promotional materials, Whova Software, videos and PowerPoint at conference. Front vendor table placement, social media recognition, verbal recognition at opening session, attendance at leadership lunch, remarks at opening session and co-title recognition.
- At least 15 staff members attended (in person)
- Health/Resource Fair, open to the public

May 20, 4–4:30 p.m., CalOptima Health Medi-Cal Overview in Spanish

Katherine Irvine Day School, 1002 W. 2nd St., Santa Ana

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

May 21, 9:30–11 a.m., CalOptima Health Medi-Cal Overview in English

Robert M. Pyles Stern Academy, 10411 Dale Ave., Stanton

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

May 21, 10 a.m.–Noon, Job Fair, hosted by Equus Workforce Solutions

Downtown Anaheim Community Center, 250 E. Center St., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 22, 9 a.m.–5 p.m., Mercy Health Mental Health Summit, hosted by Mercy Health

Sheraton Cerritos, 12725 Center Court Dr., Cerritos

- Sponsorship fee: $5,000; included a resource table, recognition on event website and reserved seating. Additionally, logo on event banners, posters, promotional materials and recognition on event website.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public

May 22, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Roberts/Juno Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 22, 4:30–6:30 p.m., Santa Ana Unified School District and the Special Education Parent Community Advisory Committee's Annual Resource Fair, hosted by Santa Ana Unified School District and supported by the Office of Orange County Supervisor Vicente Sarmiento and the City of Santa Ana Mayor Pro Tem Benjamin Vazquez

Godinez Fundamental School, 3002 E. Centennial Rd., Santa Ana

- 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

May 24, Noon–4 p.m., Good Life Celebration Health Fair, hosted by LOT318

Gomez Community Center, 1701 Atwood Ave., Placentia

- Sponsorship fee: $5,000; included a resource table, recognition on event website and social media. Additionally, sponsorship recognition on banner.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 27, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Benmore/Canfield Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 28, 10 a.m.–1 p.m., Job Fair, hosted by Anaheim Workforce Connection

Downtown Anaheim Community Center, 250 E. Center St., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 28, 1–4 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Del Monte/ Westchester Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 30, 9 a.m.–4 p.m., No-Cost Breast Cancer Screening Mammogram Event, hosted by CalOptima Health in partnership with Alinea Medical and Northgate Gonzalez Market

Northgate González Market, 720 W. La Palma Ave., Anaheim

- At least five staff members attended (in person)
- Health/Resource Fair, open to the public

May 31, 9 a.m.–1 p.m., Summer Health Fair, hosted by Friends of Family Health Center

Friends of Family Health Center, 13152 Newport Ave., Tustin

- Sponsorship fee: $15,000; included a resource table.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

May 31, 10 a.m.–Noon, Family Fun at the Park Resource Event, hosted by Think Together

Santiago Park, 600 E. Memory Ln., Santa Ana

- 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

June 2025

June 1, 2–5 p.m., Con Orgullo OC, hosted by the LGBTQ Center OC

LGBTQ Center OC, 305 E. 4th St., Santa Ana

- Sponsorship fee: $1,000; included a resource table.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

June 2, 5:30–7 p.m., CalOptima Health Medi-Cal Overview in Spanish

El Modena Family Resource Center, Virtual

- At least one staff member presented
- Community-based organization presentation, open to members/community

June 7, 9 a.m.–1 p.m., Community Resource Fair, hosted by CalOptima Health and the City of Costa Mesa supported by Orange County Supervisor Katrina Foley and Assemblywoman Cottie Petrie-Norris

Lions Park, 1845 Park Ave., Costa Mesa

- At least 10 staff members to attend (in person)
- Health/Resource Fair, open to the public

June 7, 10 a.m.–2 p.m., Dia de los Niños/ Day of the Child and Family Resource Fair, hosted by Bikers Against Child Abuse in collaboration with Higher Ground and The Raise Foundation

Lincoln Park, 1535 E. Broadway, Anaheim

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

June 8, 10 a.m.–2 p.m., Puertas Abiertas: Fería de Verano, hosted by Casa de la Familia

St. Anthony Claret Church, 1450 E. La Palma Ave., Anaheim

- Sponsorship fee: $10,000; includes a resource table.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

June 12, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Frontera Street Neighborhood

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

June 13, 11 a.m.–4 p.m., Brain Wellness Symposium and Resource Fair, hosted by OC Brain Health Initiative

Norma Hertzog Community Center, 1845 Park Ave., Costa Mesa

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

June 14, Noon–6 p.m., Juneteenth Festival, hosted by the Orange County Heritage Council

Centennial Regional Park, 3000 W. Edinger Ave., Santa Ana

- At least four staff members to attend (in person)
- Health/Resource Fair, open to the public

June 18, 9:30 a.m.–12 p.m., Senior Expo, hosted by the City of Fountain Valley

The Center at Founders Village Senior and Community Center, 17967 Bushard St., Fountain Valley

- Sponsorship fee: $1,000; includes a resource table, organization logo on event banner and announcement of sponsorship during event.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

June 19, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Winston/Magnolia Neighborhood

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

June 22, 11 a.m.–3 p.m., Mindful Love: Connecting Deeper Couples Workshop, hosted by The H4H Foundation

Tandoori Cuisine of India, 1132 E. Katella Ave., Orange

- Sponsorship fee: $10,000; includes prominent recognition at the event and highlights of organization's wellness initiatives throughout materials during workshop.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

June 24, 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

June 26, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Lido Lane Neighborhood

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

June 28, 9 a.m.–1 p.m., 15th Annual Alzheimer's Latina Caregiver Recognition Day, hosted by Alzheimer's Orange County

Amistad Medical Senior Clinic, 201 S. Broadway Ave., Santa Ana

- Sponsorship fee: $10,000; includes prominent recognition at the event and highlights of organization's wellness initiatives throughout materials during workshop.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

June 28, 9 a.m.–1 p.m., Walk/Run to End Child Marriage and Human Trafficking, hosted by Global Hope 365

Cedar Grove Park, 11385 Pioneer Rd., Tustin

- Sponsorship fee: $1,000; includes organization name at the event, social media campaign posts, and five event tickets.
- At least five staff members to attend (in person)
- Health/Resource Fair, open to the public

These sponsorship request(s) and community event(s) met the requirements of CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at:
https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

Board-Approved Strategic Initiatives Executive Summary – Report Period: January 2025 – March 2025

CalOptima Health's Board of Directors has authorized $1,422.5 million in funding and investment in programs and strategic initiatives to improve community and member health and wellness. Detailed impact summary reports are attached.

Exhibit 1: Board Approved Initiatives (as of March 31, 2025)

Board-approved Initiatives	INITIATIVE LEADER	Program Status	Payment Status	Board Approved Amount	Spent Amount	Additional Amounts Committed	Resource Available[2]	Duration
Community Outreach and Investments								
Adult Expansion Outreach Strategy	Thompson	In progress	In Progress	$ 7.6	$ 3.9	$ 2.8	$ 0.9	01/01/2024 - 06/30/2025
CalFresh and Redetermination Outreach	Thompson	In progress	In Progress	$ 6.0	$ 4.0	$ 0.1	$ 1.9	04/04/2024 - 06/30/2025
CalFresh Outreach Strategy	Thompson	In progress	In Progress	$ 2.0	$ 2.0	$ (0.0)	$ 0.0	04/01/2022 - 12/31/2022
CalOptima Health Community Reinvestment Program	Rose	Not yet started	Not yet started	$ 38.0	$ -	$ -	$ 38.0	CY 2024
Coalition of OC Community Health Centers	Laverdiere	In progress	In Progress	$ 50.0	$ 20.0	$ 30.0	$ -	FY 2023 - FY 2027
Community Living Project	Bruno-Nelson	In progress	In Progress	$ 18.0	$ 0.4	$ -	$ 17.6	FY 2024 - TBD
Garden Grove Recovery Center Development and Maintenance	Bruno-Nelson	In progress	In Progress	$ 10.5	$ 0.5	$ 0.6	$ 9.4	TBD
General Awareness and Brand Development	Thompson	In progress	In Progress	$ 4.7	$ 3.7	$ 0.7	$ 0.4	Ongoing
Homeless Health Initiative	Bruno-Nelson	In progress	In Progress	$ 66.0	$ 47.2	$ 16.0	$ 2.8	Multiple
Housing and Homelessness Incentive Program	Bruno-Nelson	In progress	In Progress	$ 87.4	$ 65.5	$ 21.5	$ 0.5	Multiple
In-Home Care Pilot Program with the UCI Family Health Center	Dabbah	In progress	Not yet started	$ 2.0	$ -	$ -	$ 2.0	09/01/2023 - 08/31/2025
Member and Population Health Needs Assessment	Laverdiere	In progress	In Progress	$ 1.3	$ 0.2	$ 1.0	$ 0.1	02/2023 - 03/2026
Mind OC Grant (Irvine)	Laverdiere	In progress	Complete	$ 15.0	$ 15.0	$ -	$ -	10/2022 - 7/2025
Naloxone Distribution Event	Carpenter	In progress	In Progress	$ 15.0	$ 12.8	$ 0.2	$ 2.0	FY 2024
NAMI Orange County Peer Support Program	Katsarov	In progress	In Progress	$ 5.0	$ 1.5	$ 3.5	$ -	CY 2023 - CY 2027
OneCare Outreach and Engagement Strategy	Thompson	In progress	In Progress	$ 1.2	$ 0.6	$ 0.5	$ 0.1	04/01/2024 - 06/30/2024
Provider Workforce Development	Laverdiere	In progress	In Progress	$ 50.0	$ 5.5	$ 24.3	$ 20.3	FY 2024 - FY 2028
Stipend Program for Masters of Social Work	Laverdiere	In progress	Complete	$ 5.0	$ 5.0	$ -	$ -	FY 2024 - FY 2028
Wellness Prevention Program	Katsarov	In progress	In Progress	$ 2.7	$ 1.2	$ 1.5	$ -	FY 2024 - FY 2027
Homeless Prevention and Stabilization Pilot Program	Hunn	Not yet started	Not yet started	$ 0.3	$ -	$ -	$ -	01/01/2025 - 06/30/2027
Subtotal				*$ 393.8*	*$ 191.8*	*$ 102.6*	*$ 98.8*	
Quality Incentive Programs								
Comprehensive Community Cancer Screening*	Pitts	In progress	In Progress	$ 50.1	$ 5.9	$ 12.7	$ 31.5	CY 2023 - CY 2027
Dyadic Services Program Academy	Katsarov	In progress	In Progress	$ 1.9	$ 0.9	$ 1.0	$ 0.0	04/30/2024 - 03/31/2026
Five-Year Hospital Quality Program[5]	Lee	In progress	In Progress	$ 153.5	$ 29.1	$ 124.4	$ -	CY 2023 - CY 2027
OneCare Member Health Incentives	Lee	In progress	Complete	$ 0.5	$ 0.3	$ -	$ 0.2	01/01/2023 - 06/30/2023
Quality Initiatives from Unearned P4V Program MY2023	Lee	In progress	In Progress	$ 23.3	$ 4.5	$ 11.4	$ 7.3	FY 2024 - FY 2025
Subtotal				*$ 270.2*	*$ 75.4*	*$ 149.6*	*$ 45.1*	
Infrastructure and Capacity Building								
Digital Transformation Strategy (DTS)[3]	Kim	In progress	In Progress	$ 100.0	$ 61.7	$ 28.6	$ 9.8	FY 2023 - FY 2025
Medi-Cal Provider Rate Increases	Kim	In progress	In progress	$ 526.2	$ 157.9	$ 368.3	$ -	07/01/2024 - 12/31/2026
Skilled Nursing Facility Access Program	Dabbah	In progress	Not yet started	$ 10.0	$ -	$ -	$ 10.0	FY 2024 - FY 2026
Subtotal				*$ 758.5*	*$ 334.5*	*$ 398.2*	*$ 25.9*	
Total				**$ 1,422.5**	**$ 601.7**	**$ 650.4**	**$ 169.8**	

[1] Amounts Committed include payments and remaining balance of open Purchase Orders and/or an estimation of amounts committed
[2] Resource Available is the amount available for new initiatives after deduction of the Amount Commited from the Board Approved Amount
[3] Amounts Committed for DTS are preliminary estimates
[4] Past Supplemental Funding
[5] Amounts Committed for the Hospital Quality Program is based on 100% earnable payout. The actual payout amount is determined based on hospital quality performance.
* Initiatives funded by IGT dollars

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/13/2025	**Initiative Name:**	Adult Expansion Outreach Strategy	**Start Date:**	7/1/2024
Reporting Period:	Jan-Mar (Q3)			**End Date:**	6/30/2025
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$7.6 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health will implement the Adult Expansion Outreach Strategy to promote awareness and enrollment of eligible adults ages 26-49 into full-scope Medi-Cal, regardless of immigration status, and enrollment in other public assistance programs (i.e., CalFresh).	- Funds are fully spent; the remaining unspent funds do not belong to Communications. - Adult Expansion Funds Breakdown: Total Spent: $2,369,315; Total Remaining: $3,210,685 (this includes 2nd payment to Community Enrollers based on CalAIM meeting on 5-9-25). - Community Enrollers: Spent $2,016,815; Remaining: $2,563,185(Half has been paid, pending 2nd payment of $2,286,743 in the coming months and AltaMed withdrew leaving an additional $499,999). - MC Expansion Sponsorship: Spent: $352,500; Remaining: $147,500 $500,000 mobile unit (project on hold). - Currently being evaluated for potential reallocation of any identified unspent funds.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop a multimedia campaign in Spanish	Number of impressions/media buys	Impressions by media type for Q3: Digital advertising: 6,950,000 Traditional advertising: 121,400,000
Conduct community outreach and enrollment events	Number of events hosted	To date, 37 community events focused on Medi-Cal expansion have been sponsored. These events included Community Enrollers for Medi-Cal enrollment/redetermination and CalFresh enrollment, a legal non-profit organization and CalOptima Health.
Increase awareness and enrollment in the Medi-Cal and CalFresh programs, with a focus on outreach to the undocumented population	Number of Community Enrollers	12 organizations were funded to have Community Enrollers for Medi-Cal enrollment,/renewals and CalFresh enrollment. We are currently halfway through the funding period.
Create a communications toolkit to promote Medi-Cal expansion	Completion of communications toolkit	Toolkit materials posted online at www.caloptima.org/CoverageForAll; materials for community partners will be printed and shipped.
CalOptima Health Mobile Unit	Mobile unit purchased by end of 2024	Community Relations was working with the contracting department to release funding to purchase two CalOptima Health mobile units. Funding was not released and this project has been put on hold.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/13/2025	**Initiative Name:**	CalFresh and Redetermination Outreach	**Start Date:**	2/2/2023
Reporting Period:	Jan-Mar (Q3)			**End Date:**	Ongoing
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$6.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health Outreach Strategy to support Medi-Cal redetermination and enroll potentially eligible CalOptima Health members in the CalFresh program.	- Spent $961,920; $1M remaining ($700k advertising, $300k member communications). - Community Relations has spent $584,000 and has $416,000 remaining. - Currently being evaluated for potential reallocation of any identified unspent funds.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop a comprehensive marketing and advertising campaign to promote Medi-Cal redetermination.	Campaign development Number of impressions/media buys	Advertising campaign launched October 2023 and ran through June 2024 in digital, print, radio, television and out-of-home.
Collaborate w/ key stakeholders by hosting community events focused on Medi-Cal redetermination and the CalFresh program throughout the county.	Number of community events Number of members served	To date, CalOptima Health sponsored 37 community events focused on Medi-Cal expansion/redetermination and CalFresh. These events included Community Enrollers for Medi-Cal enrollment/redetermination and CalFresh enrollment, a legal non-profit organization and CalOptima Health.
Fund Community Enrollers to support members with Medi-Cal renewals and enrollment in CalFresh.	Number of Community Enrollers	12 organizations were funded to have Community Enrollers for Medi-Cal enrollment/renewals and CalFresh enrollment. We are currently halfway through the funding period. The first round of funding is from October 2025-September 2026 and second round is from November 2025-October 2026.
Community Enrollers to ensure as many members enroll/retain Medi-Cal coverage throughout the resumption of redetermination.	Number of completed membership enrollment and renewal applications	To date, Community Enrollers have completed and submitted 3,049 Medi-Cal applications, 798 Medi-Cal renewals and 1,296 CalFresh applications.
Community Enrollers to engage members in the communty to provide Medi-Cal renewal assistance and CalFresh enrollment service	Number of community events	Community Enrollers have attended 608 additional community events to support Medi-Cal expansion/redetermination and CalFresh.

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CalOptima Health

Community Investment Status Report
Initiative: Community Enrollers

Partner Organization	NOFO Round	Program Title	Program Dates	Program Metrics	Grant Amount	Payments To Date	Grant Status
Abrazar, Inc.	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 200,000	$ 100,000	In Progress
Camino Health Center	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 250,000	$ 125,000	In Progress
Community Action Partnership of OC (CAPOC)	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 365,000	$ 182,500	In Progress
Give for a Smile	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 233,628	$ 116,814	In Progress
Orange County United Way	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 354,408	$ 177,204	In Progress
Serve the People Community Health Center	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 383,020	$ 191,510	In Progress
Vista Community Clinic	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 207,430	$ 103,715	In Progress
Community Health Initiative of OC (CHIOC)	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	11/1/25 - 10/31/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 500,000	$ 250,000	In Progress
Friends of Family Health Center	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	11/1/25 - 10/31/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 230.246	$ 115,123	In Progress
Latino Health Access	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	11/1/25 - 10/31/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 500.000	$ 250,000	In Progress
Mental Health Association of Orange County	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	11/1/25 - 10/31/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 349.593	$ 174,796.50	In Progress
Southland Integrated Services, Inc.	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	11/1/25 - 10/31/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 500.000	$ 250,000	In Progress
					$	$	
					$	$	
					$	$	
					$	$	

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/13/2025	**Initiative Name:**	CalFresh Outreach Strategy	**Start Date:**	3/3/2022
Reporting Period:	Jan-Mar (Q3)			**End Date:**	Ongoing
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$2.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalFresh Outreach Strategy is designed to enroll potentially eligible CalOptima Health members in the CalFresh program to promote food security.	Community Relations has fully spent funds. Next steps include: 1) Communications is planning to send a targeted mailer to members who may be eligible for the CalFresh program. The mailer will be sent after the Federal and State budget and guidelines for CalFresh eligibility are confirmed. 2) Equity and Community Health is planning to send a targeted text message to members who may be eligible for the CalFresh program. The mailer will be sent after the Federal and State budget and guidelines for CalFresh eligibility are confirmed.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop a comprehensive marketing and advertising campaign to promote enrollment in CalFresh.	Campaign development Number of impressions/media buys	CalOptima Health spent $239,135 on campaign development. We anticipate garnering more than 400 million impressions on a total media placement budget of $1,190,200 (April 2022 to December 2024). In Q2 of FY 25, CalOptima Health began discussions about how to extend the campaign.
Collaborate w/ key stakeholders by hosting community events focused on the CalFresh program throughout the county.	Number of community events Number of members served	This fiscal year, CalOptima Health hosted 13 large scale events that included CalFresh enrollment assistance with the support of Socail Services Agency and funded Community Enrollers. At these events, approximately 13,000 members and community members were served.
Produce direct mail promoting the availability of CalFresh benefits.	Number of mailers sent	Mailers are on hold given uncertainty around program requirements and budget.
Increase enrollment in CalFresh program.	Number of members supported by CalFresh	SSA reports a 34% growth in CalFresh enrollment from January 2021 thru May 2024, as compared to statewide enrollment of 30.8%. To date, funded Community Enrollers have submitted 1,296 CalFresh applications.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/13/2025	**Initiative Name:**	CalOptima Health Community Reinvestment (CR) Program	**Start Date:**	11/1/2023
Reporting Period:	Jan-Mar (Q3)			**End Date:**	2026
Program Status:	Not Started	**Initiative Owner:**	Dr. Michaell Rose	**Approved Amount:**	$38.0 Million
Payment Status:	Not Started				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
As part of the Comprehensive Quality Strategy and Population Health Management Policy Guide, DHCS is requiring all MCPs to reinvest a portion of their net income into community-driven solutions that address social drivers of health and reduce health disparities as follows: - 5% of the portion of annual net income that is less than or equal to 7.5% of revenue for the year; and - 7.5% of the portion of annual net income that is greater than 7.5% of revenue for the year.	- Oct 2023: BOD approved initial commitment of up to $38 million to fund the Community Reinvestment Program - Feb 7, 2025: Final All Plan Letter (APL) 25-004 Community Reinvestment Requirements released and CalOptima Health established internal stakeholder workgroup to develop program per final DHCS guidance. - Mar 2025: Developed Community Reinvestment policy (Draft) - Jan-Mar 2025: Reviewed CY 2024 Voluntary Investments for consideration of Community Reinvestment activites. - Next Steps: Q3 2025: Community Reinvestment workgroup to be launched

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Establish Community Reinvestment Program internal and external stakeholder workgroups	Establish internal stakeholder workgroup by Q1 2025 and external stakeholder workgroup by Q3 2025.	Identified key stakeholders for workgroup that will convene in Q3 2025.
Develop Community Reinvestment Program activities and workplan	Community Reinvestment Program Workplan developed by Q2 2025.	Community Reinvestment Program Workplan finalized. Submission of initial Community Reinvestment Plan is due to DHCS in Q3 CY 2026.
Obtain stakeholder input on Community Reinvestment through engagement with Member/Provider Advisory Committees	Stakeholder committees convened for community input on investments	Presented high-level overview of the Community Reinvestment requirements at the MAC/PAC meeting on April 10, 2025.
Allocate required portion of net income in improving the health and wellbeing of members through locally driven innovations and whole-person approach	% of annual net income reinvested in local communities	Not yet started
	Number of community reinvestment programs implemented	Not yet started

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/9/2025	**Initiative Name:**	Coalition of OC Community Health Centers	**Start Date:**	6/1/2022
Reporting Period:	Jan-Mar (Q3)			**End Date:**	6/30/2027
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$50.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Coalition's five-year, $50 million initiative with participating subgrantee community health centers to enhance access, quality, and further strengthen the safety net system across Orange County. The initiative focuses on building capabilities of participating clinics related to data and quality improvement, care delivery, and transitioning towards value-based care.	The program is currently in its third year. A total of 27 clinics are participating in the initiative.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Provide monitoring, guidance, and support to subgrantee implementation projects from Year 1 to Year 3.	% of planned milestones that have been successfully achieved within the specified timeframe	97% completed: Project status reporting on a quarterly basis collected and reviewed by IHQC. Developed monitoring plans for health centers needing higher levels of technical assistance.
Provide timely technical assistance and support to subgrantees over 5 year grant period.	Number of training workshops, webinars, and sessions conducted	80% completed: IHQC developed 2025 training schedule that includes bi-monthly peer group meetings for clinics, workshops focused on data and quality improvement, webinars on VBC topics such as empanelment, and quality improvement trainings.
Ensure data collection and reporting compliance over 5 year grant period.	Timely submission of reports by health centers with feedback from technical assistance staff	60% completed: Standardized quarterly project status reports and project dashboards include tailored feedback loop from IHQC Team.
Build the capacity of Coalition to support health centers in practice transformation and quality improvement from Years 2 to 5.	-Positions outlined in the budget hired -% of Coalition staff completed technical assistance trainings	60% completed: Coalition staff are actively participating in IHQC's training programs and undergoing training in Patient-Centered Medical Home to assist health centers. Plans for Coalition staff to shadow IHQC staff to further develop Coalition staff's capacity. Some QI and VBC open positions remain.
Support health center staff in development of value-based quality improvement and data strategic plans.	Creation of health center VBC strategic plans	50% completed: Coalition partnered with Curis Consulting to conduct strategic planning sessions with five of the participating health centers to focus on quality improvement and data analytics. Development of strategic plans will be expanded to remaining health centers.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/13/2025	**Initiative Name:**	Community Living Project	**Start Date:**	2/2023
Reporting Period:	Jan-Mar (Q3)			**End Date:**	TBD
Program Status:	In Progress	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$18.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
This project envisioned co-locating a recuperative care and PACE program designed specifically for unhoused older adults (55+ years) and primarily being discharged from hospitals in Orange County. The program would offer full on-site medical, dental, behavioral, and optical care with the option to reside at the center until permanently housed. Enrollment in the PACE program would continue post-discharge, ensuring continued access to medical and social services, and tenancy services.	Currently being evaluated for potential reallocation of unspent funds.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Identify and secure a building and complete necessary renovation.	Close escrow on building. Complete architectural drawings and approvals. Secure a general contractor. Complete renovations.	TBD
Ensure members discharged from the program are connected to permanent and/or supportive housing.	80% of older adults discharged from the program will be connected to permanent and/or supportive housing.	TBD
Ensure members discharged from the program continue to receive medical support from the PACE program.	75% of older adults discharged from the program will continue to receive PACE services.	TBD
Ensure members discharged from the program remain permanently housed.	75% of older adults discharged from the program will remain permanently housed 2 years post discharge.	TBD
Delivery of care to CalOptima Health members who are eligible for the program.	75% of older adults in the program will successfully utilize the services offered	TBD

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/13/2025	**Initiative Name:**	Garden Grove Recovery Center Development and Maintenance	**Start Date:**	9/1/2023
Reporting Period:	Jan-Mar (Q3)			**End Date:**	TBD
Program Status:	In Progress	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$10.5 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Street Medicine Support Center is a service-enriched supportive housing facility focused on providing individuals enrolled in the Garden Grove Street Medicine Program with continued medical wraparound services, housing navigation, and Enhanced Care Management. These services will assist in retaining housing, improving health status, and maximizing the ability to live and (if applicable) work in the community. There will be 50 furnished, private rooms and an outdoor space for socialization and overall mental wellness.	- Held meeting with the City of Garden Grove to discuss timeline for plan submittal. - Design development phase scheduled to be complete by June 2025 with construction documents submitted to the City of Garden Grove planning department by July 2025.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Secure architectural firm and complete design and plan approval process	Firm contracted and plans approved by City of Garden Grove	Architect contracted. Construction documents scheduled for submission to the City of Garden Grove in July 2025.
Complete construction	Certificate of Occupancy secured date	Once the construction documents are submitted and approved, start the process of identifying a general contractor and create a construction timeline including a completion date.
Secure a provider	Contract with provider successfully executed	Process of securing a provider to begin once the construction timeline is developed.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/13/2025	**Initiative Name:**	General Awareness and Brand Development	**Start Date:**	4/1/2023
Reporting Period:	Jan-Mar (Q3)			**End Date:**	6/30/2026
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$4.7 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
To create and implement a General Awareness and Brand Development campaign that will support enhanced recognition of CalOptima Health's key role in the community, improve understanding of our values and vision, and better reach our members.	- New assets during Q3 FY25 utilized to execute hyperlocal ads. Response continues to be at or above plan, based on performance data supplied by ad agency. - Next step is to continue to run ads for a second FY, as approved by the Board.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Brand platform development and consulting	Research, strategy, brand messaging and design platforms, brand concept and guidelines	-Development of assets complete -Discussed next steps of any future refresh of campaign
Campaign creation and execution	Media plan, campaign development and campaign production	-Media plan fully implemented and active during Q3 FY25, including developing asset for the hyperlocal ads (gas stations and window clings)
Campaign media buys	Media placements, monitoring and reporting	-Media placements resumed in Q3 FY25 for bus shelters, billboards and selected editions of the Orange County Business Journal. -Performance of digital assets was strong, with 38 million campaign impressions to date and 7.1 million completed video views through March 2025

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/13/2025	**Initiative Name:**	Homeless Health Initiative	**Start Date:**	2019
Reporting Period:	Jan-Mar (Q3)			**End Date:**	TBD
Program Status:	In Progress	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$61.7 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Homeless Health Initiative (HHI) began in 2019 when the Board of Directors established a fund to support programs that improved the health of members experiencing homelessness. This fund has supported many projects and programs and continues to support the Homeless Clinic Access Program (HCAP), Outreach and Engagement, and Street Medicine project. Overall, it is helping to increase access to medical services for our members.	- The Street Medicine program is currently operational in three cities: Garden Grove, Costa Mesa and Anaheim. The team sought board approval to expand the program to one new city in 2025 and Santa Ana was selected. An RFP was released for the service provider for the Santa Ana program and that selection will occur in Q2 of 2025. - HCAP continues to operate at 9 shelter sites through the partnership of five local community clinics and homeless shelter operators. - Currently being evaluated for potential reallocation of any identified unspent funds.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop two new programs and/or services to meet the unique needs of our members experiencing homelessness.	Program implementation	Developed and launched and continue to maintain the Homeless Clinic Access Program (HCAP) and the Street Medicine program.
Provide 200 participants with point of care service through each of the Garden Grove, Anaheim and Costa Mesa Street Medicine programs.	Number of members served	670 members were served across all three sites.
Connect 90% of members served through the Garden Grove Street Medicine program to enhanced care management and community supports.	Percent of members connected	98% of individuals enrolled in the program have been connected to ECM and CS services.
Connect 80% of members served through the Garden Grove Street Medicine program to a primary care physician (PCP).	Percent of members connected	73% of individuals enrolled have been connected to a PCP; the teams continue to work on supporting those not yet enrolled and anticipate this number growing as they build trusting relationships.
Connect 25% of members served through the Garden Grove Street Medicine program to housing.	Percent of members connected	So far, 17% of individuals have been housing; the primary challenge being the availability of housing.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/13/25	**Initiative Name:**	Homeless Health Initiative	**Start Date:**	2019
Reporting Period:	Jan-Mar (Q3)			**End Date:**	TBD
Program Status:	In Progress	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$61.7 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Homeless Health Initiative (HHI) began in 2019 when the Board of Directors established a fund to support programs that improved the health of members experiencing homelessness. This fund has supported many projects and programs and continues to support the Homeless Clinic Access Program (HCAP), Outreach and Engagement, and Street Medicine project. Overall, it is helping to increase access to medical services for our members.	- The Street Medicine program is currently operational in three cities: Garden Grove, Costa Mesa and Anaheim. The team sought board approval to expand the program to one new city in 2025 and Santa Ana was selected. An RFP was released for the service provider for the Santa Ana program and that selection will occur in Q2 of 2025. - HCAP continues to operate at 9 shelter sites through the partnership of five local community clinics and homeless shelter operators. - Currently being evaluated for reallocation of any identified unspent funds.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Increase access to primary and preventative care services for members experiencing homelessness.	Number of HCAP visits conducted across the nine program sites.	In Q1 of 2025, 1,416 visits were conducted with members across the nine HCAP sites.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/6/2025	**Initiative Name:**	Housing and Homelessness Incentive Program	**Start Date:**	04/01/22
Reporting Period:	Jan-Mar (Q3)			**End Date:**	TBD
Program Status:	In Progress	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$87.4 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
HHIP is a voluntary program that aimed to improve health outcomes and access to whole person care services by addressing housing insecurity and instability for the Medi-Cal population. Through this program, CalOptima Health earned $72.9 million of the $83 million for which it was eligible. These funds have been and will continue to be invested into the community to improve the experience of members at-risk for and experiencing homelessness.	- Staff continue to steward 75 active grant projects/agreements that are geared toward improving service to our members experiencing homelessness, including those that increase provider service capacity, support the development of housing projects, and seek to influence systems change. - HHIP Notice of Funding Opportunity Round 4 was released in January 2025 and applications were due in March. Funding was available for systems change and for equity grants to organizations working to resolve social issues for members at risk for homelessness. A total of 27 eligible applications were received across the two funding priorities. Staff will bring funding recommendations to the board in June 2025. - Currently being evaluated for potential reallocation of any identified unspent funds.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Address housing insecurity and instability among Medi-Cal members.	Earn $83.7M in incentives	Earned $73 of the potential $83.7M (87%).
	Percentage increase / increased number of housed members among unhoused members	Increased percentage and number of unhoused members housed from 1.3% in June 2022 to 34.3% as of October 2023, representing 3,585 members.
	Percentage of members that stayed stably housed	Of members experiencing homelessness in early 2023 that were connected to housing, 69% remained housed through April 2024 (the next measurement period).
Expend all funds contributed to this effort.	Number of grant awards	124 grant awards have been made and are in various stages of implementation.

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CalOptima Health

Housing and Homeless Incentive Program Capital Investments: Status Report

Partner Organization (this column repeats on the next page)	HHIP NOFO Round	Address	SPA	Contract Execution Date	Contract End Date	Total Contract/ Agreement Amount
City of Anaheim - Housing and Community Development Department	2	9150 E. Orangewood Ave. Anaheim, CA 92802	North	12/1/2023	12/1/2024	$1,500,000.00
Community Action Partnership OC	1	10821, 10786, 10782, 10881 Garza Ave. (Senior Duplex units A and B), Anaheim, CA 92802 9301 Katella Ave. (Duplex units A and B), Anaheim, CA 92804	North	4/1/2023	3/31/2024	$98,340.00
The Salvation Army Orange County	1	1401 S. Salvation Pl., Anaheim, CA 92805	North	6/1/2023	3/31/2024	$4,100,000.00
Jamboree Housing Corporation	2	1108 N. Harbor Blvd., Santa Ana, CA 92703	Central	12/1/2023	12/1/2024	$4,721,241.00
National Community Renaissance of California	2	1314 N. Angelina Dr., Placentia, CA 92870	North	12/1/2023	12/1/2024	$1,334,677.00
WISEPlace	2	23240 Orange Ave. #4, Lake Forest, CA 92630	South	12/1/2023	11/30/2025	$1,000,000.00
Pathways of Hope OC	1	504/506 W. Amerige Ave., Fullerton, CA 92832	North	4/1/2023	3/30/2025	$1,500,000.00
Mercy Housing California	2	480 S. Batavia St., Orange, CA 92868	North	12/1/2023	12/1/2025	$1,500,000.00
Golden State Recuperative Care	3	150 Cecil Place, Costa Mesa, CA 92627	Central	6/1/2024	5/31/2034	$3,500,000.00
Mind OC/Be Well OC	3	7800 Marine Way, Irvine, CA 92618	South	6/1/2024	5/31/2034	$5,000,000.00
Shelter Providers of Orange County, Inc., DBA HomeAid Orange County	2	617, 625, 637 W. La Veta Ave., Orange, CA 92686	North	12/1/2023	12/31/2025	$1,400,000.00
Illumination Foundation	2	918 N. Bewley St., Santa Ana, CA 92703	Central	12/1/2023	11/30/2025	$3,000,000.00
Community Development Partners	2	2274 Newport Blvd., Costa Mesa, CA 92627	Central	1/1/2024	12/1/2025	$8,000,000.00
Kingdom Causes dba City Net	2	8694 Western Ave., Buena Park, CA 90620	North	12/1/2023	6/30/2026	$1,337,170.49
Friendship Shelter	1	2435 S. El Camino Real, San Clemente, CA 92672	South	4/1/2023	9/30/2025	$3,850,000.00
Anaheim Housing Authority	2	1251 N. Harbor Blvd., Anaheim, CA 92801	North	12/1/2023	12/1/2025	$3,878,420.00
City of Yorba Linda	2	5086 Avocado Circle, Yorba Linda, CA 92886	North	12/1/2023	12/1/2024	$3,100,000.00
Families Forward	2	1852 San Juan St., Tustin, CA 92780	Central	12/1/2023	12/1/2025	$2,500,000.00
American Family Housing	1	15222 Jackson St., Midway City, CA 92655 and 15081 Adams St., Midway City, CA 92655	Central	6/1/2023	3/31/2028	$2,951,660.00
The Eli Home, Inc.	2	3175 W. Ball Road, Anaheim, CA 92804	North	12/1/2023	12/1/2026	$5,000,000.00
City of Anaheim/Anaheim Housing Authority	1	120 S. State College Blvd., Anaheim, CA 92806	North	5/1/2023	4/30/2026	$2,000,000.00
Korean Community Services dba KCS Health Center	1	13091 Galway St., Garden Grove, CA 92844	Central	4/1/2023	3/31/2026	$2,500,000.00
Hart Community Homes	3	220 N. Lemon St., Fullerton, CA 92832	North	6/1/2024	5/31/2034	$4,000,000.00
Illumination Foundation	3	3708 W. Washington St., Santa Ana, CA 92703	Central	6/1/2024	5/31/2034	$3,500,000.00
Casa Youth Shelter	3	10935 Reagan St., Los Alamitos, CA 90720	North	8/1/2024	7/31/2034	$4,000,000.00
Orange County Housing Finance Trust	1	N/A as these ADUs will be cross-county	ALL	5/1/2023	4/30/2027	$4,000,000.00
C&C Development	2	7101 Lincoln Ave., Buena Park, CA 90620	North	1/1/2024	12/1/2026	$8,000,000.00
City of Brea	2	323 N. Brea Blvd., Brea, CA 92821	North	12/1/2023	12/1/2027	$6,028,491.51

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CalOptima Health

Housing and Homeless Incentive Program Capital Investments: Status Report

Partner Organization	Projected Completion Date	Number of Units Proposed	Number of Units Completed	Previous Site Visit Dates	Next Site Visit Dates	Total Payments To Date	Total Payments Remaining	Grant Open or Closed
City of Anaheim - Housing and Community Development Department	12/30/2023	102	102	10/22/2024	N/A	$1,500,000	$0	Closed
Community Action Partnership OC	3/31/2024	5	5	9/28/2023	N/A	$98,340	$0	Closed
The Salvation Army Orange County	3/31/2024	72	72	6/22/2023	N/A	$4,100,000	$0	Closed
Jamboree Housing Corporation	3/31/2024	91	91	11/20/2024	N/A	$4,721,241	$0	Closed
National Community Renaissance of California	7/30/2024	65	65	5/13/2024	N/A	$1,334,667	$0	Closed
WISEPlace	11/30/2025	5		3/19/2025	N/A	$1,000,000	$0	Open
Pathways of Hope OC	12/31/2024	15	14	9/25/2024	N/A	$1,500,000	$0	Closed
Mercy Housing California	1/30/2025	50	50	12/9/2024	N/A	$1,500,000	$0	Closed
Golden State Recuperative Care	3/31/2025	30		1/14/2025	7/13/2025	$2,000,000	$1,500,000	Open
Mind OC/Be Well OC	5/31/2025	35		-	-	$0	$5,000,000	Open
Shelter Providers of Orange County, Inc., DBA HomeAid Orange County	12/31/2025	6		11/19/2024	5/6/2025	$1,400,000	$0	Open
Illumination Foundation	11/30/2025	11		11/7/2024	5/14/2025	$3,000,000	$	Open
Community Development Partners	8/1/2025	87		9/18/2024	5/20/2025	$8,000,000	$0	Open
Kingdom Causes dba City Net	6/30/2026	20		-	4/21/2025	$1,337,170	$0	Open
Friendship Shelter	9/30/2025	11		3/19/2025	10/1/2025	$3,850,000	$0	Open
Anaheim Housing Authority	9/30/2025	89		10/22/2024	5/13/2025	$3,878,420	$0	Open
City of Yorba Linda	9/30/2025	66	64	11/13/2024	N/A	$3,100,000	$0	Closed
Families Forward	11/1/2025	8		10/31/2024	5/19/2025	$2,500,000	$0	Open
American Family Housing	3/31/2028	111		10/31/2024	5/20/2025	$2,951,660	$0	Open
The Eli Home, Inc.	2/1/2026	11		-	5/13/2025	$5,000,000	$0	Open
City of Anaheim/Anaheim Housing Authority	3/31/2026	32		10/22/2024	5/13/2025	$2,000,000	$0	Open
Korean Community Services dba KCS Health Center	3/31/2026	100		9/18/2024	5/6/2025	$2,500,000	$0	Open
Hart Community Homes	5/30/2026	20		11/6/2024	5/8/2025	$0	$4,000,000	Open
Illumination Foundation	5/30/2026	30		11/7/2024	5/14/2025	$1,895,575	$1,604,425	Open
Casa Youth Shelter	7/31/2026	14		3/6/2025	10/1/2025	$0	$4,000,000	Open
Orange County Housing Finance Trust	4/30/2027	34		11/30/2023	N/A	$4,000,000	$0	Open
C&C Development	1/30/2027	55		2/18/2025	10/15/2025	$8,000,000	$0	Open
City of Brea	5/31/2027	40		10/29/2024	5/22/2025	$6,028,492	$0	Open
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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/13/2025	**Initiative Name:**	In-Home Care Pilot Program	**Start Date:**	9/1/2023
Reporting Period:	Jan-Mar (Q3)			**End Date:**	8/31/2025
Program Status:	In Progress	**Initiative Owner:**	Dr. Zeinab Dabbah	**Approved Amount:**	$2.0 Million
Payment Status:	Not Started				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health has contracted with UCI to partner with home-based care Dispatch Health services to provide services to all CalOptima Health members assigned to a UCI FQHC with acute medical needs. The program provides same-day high acuity care, focused medical intervention within 24 to 72 hours post discharge, and hospital-at-home alternative care in lieu of hospitalizations.	- Program expanding and being utilized successfully to appropriate members to ensure reduction in unnecessary hospital and ER visits. Evidence shows that there was a better coordination of care, increased patient satisfaction and reduction in avoidable utilization for acute care patients. - CalOptima Health continues to meet with UCI leadership to expand the program to other newly acquired UCI facilities such as Fountain Valley. Care coordination with UCI embedded CalOptima Health nursing staff has been implemented. - Currently being evaluated for potential reallocation of any identified unspent funds.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Improve access to in-home acute care	Number of members seen in in-home acute care	248 members were seen in in-home acute care that were referred by UCI FQHCs *Data is from Jan - Dec 2024
Reduce emergency department (ED) visits by 20%	Percentage of members seen through in-home acute care instead of ED	109 members seen in in-home care acute care *Data is from Jan - Dec 2024
Achieve utilization of Dispatch Health by at least 10%	911 Diversion Rate	11.6% of members were diverted to Dispatch Health in place of 911 service *Data is from Jan - Dec 2024
Reduce hospital observation stay by 10%	Observation Diversion Rate	8% of members seen by Dispatch Health were observed in ED *Data is from Jan - Dec 2024
Reduce hospital admission by 10%	Hospital Diversion Rate	2.1% reduction of hospital admission for members seen by Dispatch Health *Data is from Jan - Dec 2024

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/9/2025	**Initiative Name:**	Member and Population Health Needs Assessment	**Start Date:**	3/14/2025
Reporting Period:	Jan-Mar (Q3)			**End Date:**	2/15/2026
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$1.3 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Conduct a comprehensive Member and Population Health Needs Assessment (MPHNA) and Health Equity Asset Mapping (HEAM) to assess the whole-person health needs and preferences of CalOptima Health members, inform the development of programs and strategic approaches and to meet the requirements of the Community Reinvestment program.	- The National Opinion Research Center (NORC) has been approved as the selected vendor to implement the MPHNA and HEAM. Additional subcontractors include CSUF Social Science Research Center, Community Action Partnership of OC (CAPOC), and Vital Research; contract effective 3/14/2025. - Project and activity timeline finalization in process. - Member and provider surveys planned to launch in August 2025.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Support meeting the requirements of DHCS population health initiatives, e.g., Population Health Management Strategy, (PNA), and Medi-Cal Transformation initiatives.	Deployment of MPHNA	MPHNA implementation launched March 2025.
Identify trends and opportunities in population health and social needs of CalOptima Health members.	MPHNA report findings produced	TBD - not yet started
Identify assets and resources avaliable in the community and conduct gap analysis.	Detailed community asset mapping and list of community investment opportunities through an interactive dashboard produced	TBD - not yet started
Develop recommendations for interventions based on assessment findings.	Final report with actionable strategies and recommendations developed and presented	TBD - not yet started

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/13/2025	**Initiative Name:**	Mind OC Grant (Irvine)	**Start Date:**	12/1/2022
Reporting Period:	Jan-Mar (Q3)			**End Date:**	7/31/2025 (extension)
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$15.0 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Mind OC received grant funding to support the construction of the second Be Well OC Campus in Irvine, CA to provide mental health and substance abuse services to all, regardless of payer. The first phase of campus development will include 75,000 sq ft. of crisis care, outpatient and residential/short term treatment options. The services are planned to support a full continuum of care needs, and will offer programs for adults, adolescents, and families (through wraparound supports).	- Site readiness activities completed. Phased operational construction on track with building progress. - Under amendment, Mind OC to submit monthly progress reports to reflect progress of design and construction. - Remaining funds are being disbursed on a monthly basis. - Construction delays have been reported due to external dependencies; ongoing monitoring and mitigation planning in progress; CalOptima Health to conduct site visit in May 2025.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Complete Package 1: Site Readiness activities, to prepare site for the construction of 75,000 square feet of the Be Well Irvine Campus – Phase 1	% of site readiness activities completed and scheduled	100% completed: Demolition, abatement, rough grading and future building pads completed by August 2023.
Complete Package 2 construction for Be Well OC Irvine Campus, and buildings ready for phased operational go-live.	% of building construction based on procurement and construction schedule	- 85% complete: completion of underground site utility work, concrete paving and walkways commenced, interior details, & wrapping up water and gas connections - Delays in construction activities; ongoing monitoring in process.
Align public and private funding to execute on the capital financing needed for Phase 1 development, for a total of $86 million.	$ amount of secured capital financing for funding Phase 1 development	100% completed: $82.7M in cash; $3.2M secure via fund flow contract with County of Orange.
Facilitate the process of provider selection and contracting for service provision at the Campus	% completion of selection process and contracting for service providers	TBD

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/13/2025	**Initiative Name:**	Naloxone Distribution Event	**Start Date:**	07/01/23
Reporting Period:	Jan-Mar (Q3)			**End Date:**	07/01/25
Program Status:	In Progress	**Initiative Owner:**	Veronica Carpenter	**Approved Amount:**	$15.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Naloxone Distribution initiative aims to increase access to Naloxone for members, with the goal of reversing fentanyl and opioid overdoses and saving lives.	- CalOptima Health has fully distributed 250,000 boxes of Naloxone via events and mail order option. - Currently being evaluated for potential reallocation of any identified unspent funds.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Purchase 250,000 doses of naloxone for distribution	Purchase Kloxxado (8 ml prescription-strength naloxone)	250,000 boxes of Naloxone were purchased and have been fully distributed in the community.
Conduct events and community outreach to distribute naloxone to members	Offer naloxone at community events in various places throughout the county	CalOptima Health hosted 1 member distribution event and two provider/community-based organization distribution events. Naloxone distribution was also included in 10+ community events hosted by CalOptima Health.
Engage providers, community organizations, city governments, public agencies, school districts and others in helping to distribute naloxone to members	Create a process for providers and other partners to obtain the naloxone using a distribution agreement	CalOptima Health established a mail order option and has fully distibuted the full supply of Naloxone.
Create a training video and communications resources to promote naloxone distribution and education	Develop sharable resources for communications and education	Communications developed a Naloxone toolkit and campaign to promote our Naloxone efforts. The toolkit included "How to Administer Naloxone" and FAQs for members, providers and communty stakeholders' use.
Establish a partnership with recovery coalitions to provide access to Naloxone	Offer an ongoing and routine allocation of Naloxone for members who are affiliated with a recovery coaltion.	CalOptima Health established a relationship with the Recovery Coalition to distribute Naloxone in the community.

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Board-Approved Initiative Status and Impact Summary

Report Date:	5/9/2025	**Initiative Name:**	NAMI Orange County Peer Support Program	**Start Date:**	1/1/2023
Reporting Period:	Jan-Mar (Q3)			**End Date:**	12/31/2027
Program Status:	In Progress	**Initiative Owner:**	Carmen Katsarov	**Approved Amount:**	$5.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
NAMI pairs trained Peer Support Mentors with CalOptima Health members to provide tailored, social support and resource navigation from hospital inpatient stay/emergency room visit to six months post-discharge. Peer Support Mentors support members in scheduling and attending follow-up primary care appointments (especially post-discharge).	-Year 1: Majority of staff were hired and trained within the first 6 months. Additional staff has been on-boarded to support the increased efforts to grow the program participation. -Year 2: Current enrollment rate into the program = 66%. Focus of peer mentors to understand root causes and provide directed support and appropriate resources.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Facilitate behavioral health transitions from hospital to home/community	Facilitate behavioral health transitions for 65% of those who are referred to the program (N=eligible members referred from hospital or ED). Success = 2+ months	Currently at 50%; Limitations around expanding partnerships with additional Emergency Departments. Working with BH team on reaching more members through community events.
Support behavioral health integration through Peer facilitating member connection to ECM.	NAMI Peer program, connect 75% of members eligible for ECM who aren't already receiving the benefit (i.e., the member receives an authorization for ECM)	Currently at 79%, exceeding the goal of 75%. Partnering directly with Abrazar for ECM referrals to one organization.
Improve CalOptima Health's HEDIS FUM1 measure	For members who are referred to the program, 85% achieve a follow-up appointment either 7 or 30 days after hospital or ED discharge	Updated metric will utilize self-reported data at intake. Peer mentors will inquire with participants on ED visits, hospitalizations, and doctor visits. With a self-reported hospital admission or ED visit, Peer mentors will determine if appropriate follow up appointment has been scheduled.
Reduce readmissions at psychiatric hospital through family and resource connection	25% reduction in psychiatric hospital admissions for members referred from the ED and having completed the program	Updated metric will utilize self-reported ED or psychiatric hospital admissions occurring during program participation.
	25% reduction in psychiatric hospital re-admissions for members referred during an inpatient stay *Establish baseline during year 1*	Updated metric will utilize self-reported ED or psychiatric hospital admissions occurring during program participation.

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Board-Approved Initiative Status and Impact Summary

Report Date:	5/13/25	**Initiative Name:**	OneCare Outreach and Engagement Strategy	**Start Date:**	07/01/2024
Reporting Period:	Jan-Mar (Q3)			**End Date:**	6/30/2025
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$1.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Expansion of the CalOptima Health OneCare outreach and engagement strategy to enroll and retain eligible CalOptima Health members who are also enrolled in Medicare.	Funds are fully allocated and will be spent by the end of FY25.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Increase outreach for CalOptima Health OneCare through continuous and heavy presence in the market with a full range of advertising tactics.	Number of media buys	For Q3, we extended the OCTA bus ads (originally slated to end mid-December 2024) to run through March 2025. We also increased outreach through TV ads (Feb-Jun 2025) and a print ad on the Southern California Senior Care Directory (Feb 2025).
Retain existing CalOptima Health OneCare members with targeted mailings.	Number of members retained	Sent two retention mailers to members in FY 2024, which resulted in decreased disenrollment of 8.5% and 5.9% respectively for April 2024 and June 2024.
Increase direct mail outreach to prospective OneCare members by customizing messages and segmenting the mailing.	Number of mailers sent to three segmented audiences (fee-for-service members, members of another Medicare Advantage plan, former OneCare members)	This strategy was implemented in October 2024 with FY 2025 funds and in coordination with the new campaign roll out. We did not use funds from this initiative for this strategy.

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Board-Approved Initiative Status and Impact Summary

Report Date:	5/8/2025	**Initiative Name:**	Provider Workforce Development	**Start Date:**	12/1/2023
Reporting Period:	Jan-Mar (Q3)			**End Date:**	FY 2028-2029
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$50.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Provider Workforce Development Initiative was approved to close gaps in Orange County ' s health care workforce and increase access to high-quality, equitable care for CalOptima Health members. The five initiatives include: educational investments to increase supply of health care professionals (non-physician), the Workforce Training & Development Innovation Fund, the Physician Recruitment Incentive Program, the Physician Loan Repayment Program, and the Orange County Health Care Workforce Development Collaborative.	- Round 1 focused on educational investments to increase the number of health care professionals. - Round 2 focused on innovative solutions for training, development, and retention of health care professionals, with an emphasis on Behavioral Health.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Implement Educational investments to increase supply of health care professionals (non-physician)	Number of health professionals in an educational program and/or receiving financial support	Estimate of approximately 1,500 health professionals
Launch Workforce Training & Development Innovation Fund	Number of behavioral heath care professionals receiving training and/or development	Estimate of approximately 350 behavioral health care professionals
Implement Physician Recruitment Incentive Program	Number of physicians recruited to close network gaps	Program planning and development initiated.
Implement Physician Loan Repayment Program	Number of physicians receiving loan repayment awards	Program planning and development initiated.
Develop Orange County Health Care Workforce Development Collaborative	Launched collaborative to increase the health care workforce in Orange County	Program planning and development initiated.

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CalOptima Health

Community Investment Status Report
Initiative: Provider Workforce Development

Partner Organization	NOFO Round	Program Title	Program Dates	Program Metrics	Grant Amount	Payments To Date	Grant Status
Chapman University	1	Reflecting OC Communities: Building a Culture of health through PA scholarships,training, local practice	7/1/24 - 12/31/29	7/24-11/24: 4 PA Students received full tuition scholarships	$ 5,000,000	$ 413,025	In Progress
Coast Community College District	1	Orange County Dual Enrollment Nursing and Allied Health Pathways	5/1/24 - 5/31/28	5/24-10/24: Golden West College nursing pipeline implementation	$ 2,040,000	$ 420,000	In Progress
Concordia University	1	Concordia Nursing Pipeline Program	8/1/24 - 8/1/29	8/24-1/25: 29 ABSN and pre-nursing students awarded scholarships	$ 5,000,000	$ 792,880	In Progress
CSU Fullerton Auxiliary Services Corporation	1	Expanding Numbers of CSUF Baccalaureate-Prepared Registered Nurses in OC	7/1/24 - 6/30/29	7/24-1/25: 10 RN-BSN stipend recipients; 54 BSN received stipends	$ 5,000,000	$ 971,357	In Progress
Orange County United Way	1	UpSkill OC	5/1/24 - 4/30/27	5/24-10/24: 17 UpSkill participants enrolled in healthcare career track	$ 1,356,300	$ 452,100	In Progress
Rancho Santiago Community College District	1	SCC Healthcare Pathways - Behavior Technician, LVN and Medical Assistant Projects	5/1/24 - 6/30/27	5/24-11/24: Classroom for Medical Assistant secured	$ 1,200,000	$ 775,219	In Progress
UCI Sue & Bill Gross School of Nursing	1	Nurse-OC: UCI Nursing Workforce Pipeline through Externships and Residencies in Orange County	5/1/24 - 6/30/29	5/24-10/24: 15 prelicensure nursing students placed in externship	$ 5,000,000	$ 538,869	In Progress
Child Guidance Center	2	Help the Helper: Strengthening Orange County's Behavioral Health Workforce	1/1/25 - 12/31/27	1/25-3/25: 29 graduate student interns; expanded to 21 university partnerships	$ 766,920	$ 216,810	In Progress
CHOC	2	Pediatric Behavioral Health Field Training Expansion	1/1/25 - 12/31/28	1/25-3/25: 30 MSW intern interviews conducted	$ 994,824	$ 248,706	In Progress
John Henry Foundation	2	Psychologist and MFT Workforce Development Program	1/1/25 - 12/31/29	1/25-3/25: 5 interns onboarded	$ 847,302	$ 155,390	In Progress
Seneca Family of Agencies	2	Seneca Family of Agencies Orange County Behavioral Health Clinical Internship Program	3/1/25 - 6/30/28	Goal: train 18 master's students in mental health	$ 996,160	$ 179,030	In Progress
Special Service for Groups	2	Professional Providers Pathway Program	1/1/25 - 12/31/29	1/25-3/25: 7 interns interviewed for second year practicum	$ 535,566	$ 106,622	In Progress
Western Youth Services	2	WYS Workforce Development Program	1/1/25 - 12/31/29	1/25-3/25: Interns to begin Fall 2025; Staff reimbursements requests submitted	$ 1,000,000	$ 200,000	In Progress
					$	$	
					$	$	
					$	$	

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Board-Approved Initiative Status and Impact Summary

Report Date:	4/29/2025	**Initiative Name:**	Stipend Program for Masters of Social Work	**Start Date:**	8/1/2023
Reporting Period:	Jan-Mar (Q3)			**End Date:**	7/31/2028
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$5.0 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Orange County Behavioral Health (OCBH) Master of Social Work Stipend Program will increase the public healthcare workforce from diverse backgrounds equipped to provide culturally and linguistically responsive care to communities in need. The program will provide a stipend of $20,000 per academic year for up to two (2) years to 36 MSW students each year at CSUF (as they receive enhanced didactic and experiential training).	- 36 students successfully enrolled in the OCBH program for 2024-2025 academic year: 21 students are continuing from 2023-2024 academic year; 15 new first year MSW award recipients - 14 grant recipients graduated between May-August 2024 and confirmed a one-year work commitment within Orange County - Simucase, the online learning platform has been integrated into all MSW advanced practicum courses

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Double the number of MSW field placements that focus on behavioral health practice with persons from vulnerable communities from 70 to 140 over 5 year grant period.	Number of MSW field placements	-70 MSW students placed in 2023-2024; 100 MSW students placed in 2024-2025 -25 new placement spots added for students within new and existing partner agencies
Award stipends to 108-180 MSW students who fully participate in the CalOptima Health MSW Stipend Program over 5 year grant period.	Number of students completing the Grant Program	-2023-2024 academic year: 36 stipends awarded; 14 recipients graduated in May -2024-2025 academic year: 36 stipends awarded; 21 to second year MSW students; 15 to first year MSW students -Total of 51 total unique MSW students awarded stipends over grant life cycle
Develop an enhanced curriculum on behavioral health including digital health literacy and telehealth.	Students' clinical competency measured by quantitative and qualitative evaluation methods	Enhanced online curriculum provided through stipend program: - Simucase learning platform as part of advanced practice - Cognitive Behavioral Therapy training: 88.9% of students reported applying the knowledge and skills learned from CBT training in field practicum
Offer career development services to all CalOptima Health MSW Stipend Program students and follow up regarding employment at 1-year post-graduation.	Number of former students with post-graduate employment	-Year 1 Post-graduation employment survey indicate all 14 graduated stipend recipients retained employment in Orange County within six months of graduation

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Board-Approved Initiative Status and Impact Summary

Report Date:	5/8/2025	**Initiative Name:**	Wellness Prevention Program	**Start Date:**	7/1/2024
Reporting Period:	Jan-Mar (Q3)			**End Date:**	6/30/2028
Program Status:	In Progress	**Initiative Owner:**	Carmen Katsarov	**Approved Amount:**	$2.7 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
This project will supplement the Mental Health Service Oversight and Accountability Commission (MHSOAC) funding to support establishment of full clinical operations and prepare Allcove South Orange County Youth Drop in Center to create sustainable service streams. Delivery of services will be supported by FTE positions learning opportunities through Stanford CAT.	- Construction began mid-January 2025, with majority of expenses on building improvements. Construction costs about 10% above budget - will reallocate and supplement with additional funding. - In partnership with Youth Advisory Group (YAG), finalized architectural and branding plans, with furniture selected and ordered end of January 2025. - Working with contractor to respecify materials with long lead times. Next progress report due July 2025. - Grand Opening delayed until 9/2025 to allow for larger attendance.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Secure a location for Allcove in South Orange County	Location secured successfully	- Secured 10,000 sq ft location for Allcove in South Orange County San Juan Capistrano.
Staff recruitment	Number of hired staff - positions to support delivery of care services in allcove model	- 4 staff members have been hired. - Interviewed for site manager and peer support specialists.
Establish intake data collection	Data collection system implementation	- WPC staff is working with allcove Team to integrate allcove datacove into intake data collection.

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Board-Approved Initiative Status and Impact Summary

Report Date:	5/13/2025	**Initiative Name:**	Homeless Prevention and Stabilization Pilot Program	**Start Date:**	1/1/2025
Reporting Period:	Jan-Mar (Q3)			**End Date:**	1/01/2028
Program Status:	Not Started	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$269,703
Payment Status:	Not Started				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
To evaluate the effectiveness of the Homeless Prevention and Stabilization program (HPSP) using a combination of administrative data and data from surveys that will be administered by faculty at the University of California, Irvine. Data will be collected for both the program participants (treatment group) and a sample of similar individuals not enrolled into the program (comparison group). HPSP aims to assist approximately 200 families and will be rolled out over a two year period.	Finalizing the execution of the contract.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Complete cohort baseline surveys, complete cohort 1 6-month surveys, and provide status update on data analysis and findings.	Report #1	TBD
Complete cohort 2 baseline surveys and provide status update on data analysis and findings	Report #2	TBD
Complete cohort 1 18-month surveys, complete cohort 2 6-month surveys, and provide status update on the data analysis and findings.	Report #3 and #4	TBD
Complete cohort 2 18-month survey ad provide a status report update on the data analysis and findings.	Report #5	TBD
Provide a draft evaluation report and final evaluation report	Report #6 and #7	TBD

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/12/2025	**Initiative Name:**	Comprehensive Community Cancer Screening and Support Program	**Start Date:**	12/02/2022
Reporting Period:	Jan-Mar (Q3)			**End Date:**	12/31/2027
Program Status:	In Progress	**Initiative Owner:**	Dr. Richard Pitts	**Approved Amount:**	$50.1 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Comprehensive Community Cancer Screening and Support Program aims to create a culture of cancer prevention, early detection and collaboration with partners to work towards a shared goal of dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have equitable access to high quality care.	Key Accomplishments for Reporting Period: December 2024 - February 2025 -Conducted Q1 grantee progress review meeting (Jan 21, 2025). -Received Q2 grantee progress reports. -Developed prototype dashboard for tracking grantee baselines, goals, and progress. -Initiated collaboration with CalAIM on grant management process improvements. -Launched General Cancer Awareness (GCA) texting campaign (Feb 18 & 25, 2025).

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Increase community and member awareness and engagement	Develop and launch a multimedia, multilingual campaign within the first four years of the program (*Data provided by Maricich)	51.8 million campaign digital ad impressions to-date 26 million digital added value impressions to-date 0.30% CTR digital channels 7.2 million completed video views | 144k digital clicks to landing page
Increase access to cancer screening for eligible member	Develop and implement a community grant initiative by year two of the Cancer Screening and Support program	Launched in September 2024. Actively in progress.
	# of CalOptima members who received appropriate cancer screening	17,813 members received screening service(s).
Improve quality and member experience during cancer screening and treatment procedures	Extend vendor contract(s) to support members through screening, diagnosis and cancer treatment starting in Year 2	Received feedback on the Research and Eval component from both City of Hope and UCI Chao Family Comprehensive Cancer Center. Continued working on refining the scope of work for the research and evaluation initiative.
	Establish contract to evaluate cancer incidence, experiences, and genomic technologies to reduce disparities in late-stage cancer diagnosis by Year 2	Received feedback on the Research and Eval component from both City of Hope and UCI Chao Family Comprehensive Cancer Center. Continued working on refining the scope of work for the research and evaluation initiative.

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Community Investment Status Report
Initiative: Cancer Screening and Support

Partner Organization	NOFO Round	Program Title	Program Dates	Program Metrics	Grant Amount	Payments To Date	Grant Status
American Cancer Society, Inc.	1	Advancing Equitable Outcomes Across the Cancer Continuum for CalO Members and Greater OC Area	9/1/24 - 8/31/26	-Support OC health systems serving CalO members through 4 QI projects to increase screening rates by 4% pt	$ 1,500,000	$ 375,000	In Progress
Celebrating Life Community Health Center	1	Using Technology Infrastructure to Close Gaps in CCS	9/1/24 - 8/31/26	12/24 - 2/25: 1,128 members served	$ 329,428	$ 82,357	In Progress
Celebrating Life Community Health Center (2)	1	Closing Gaps in Cancer Screening	9/1/24 - 8/31/26	Hired 2 CHW (FTE), 1 Patient Navigator (FTE), 1 Provider (FTE), IT Analyst (part time), Marketing Associate (part time)	$ 1,290,575	$ 322,643.75	In Progress
Families Together of Orange County	1	C3 Health Initiative: Cervical, Colorectal and Breast Cancer Screening Program - Capacity Building	9/1/24 - 8/31/26	12/24 - 2/25: 10,530 members served	$ 1,500,000	$ 375,000	In Progress
Friends of Family Health Center	1	Standardizing Screening Mammograms within Primary Care Setting	9/1/24 - 8/31/26	12/24 - 2/25: 145 members served BCS: 145	$ 554,875	$ 138,718.75	In Progress
Hurtt Family Health Clinic, Inc.	1	Universal Cancer Screening Program: SDOH, Patient Motivation to Early Detection & Timely Access to Care	9/1/24 - 8/31/26	12/24 - 2/25: 1,051 members served BCS: 235, CCS: 462, COL: 354	$ 1,018,600	$ 254,650	In Progress
Korean Community Services, Inc.	1	Orange County Asian American Cancer Partnership (OCAACP)	9/1/24 - 8/31/26	12/24 - 2/25: 1,129 members served BCS: 315, CCS: 221, COL: 498, LUNG: 95	$ 3,000,000	$ 750,000	In Progress
Laguna Beach Community Clinic	1	Cancer Screening and Support for Disadvantaged Patients	9/1/24 - 8/31/26	12/24 - 2/25: 509 members served BCS: 48, CCS: 227, COL: 234	$ 116,000	$ 29,000	In Progress
Latino Health Access	1	Juntes Contra el Cancer! / Together Against Cancer!	9/1/24 - 8/31/26	12/24 - 2/25: 33 members served 30 CHWs trained.	$ 1,500,000	$ 375,000	In Progress
mPULSE Mobile, Inc.	1	Equitable Cancer Prevention with Targeted Member Screening Communications	9/1/24 - 8/31/26	12/24 - 2/25: 225,356 unique members outreached via texting campaigns	$ 1,197,625	$ 299,406.25	In Progress
Share Ourselves Corporation	1	Share Ourselves: Cancer Screening	9/1/24 - 8/31/26	12/24 - 2/25: 706 members served	$ 362,500	$ 90,625	In Progress
The G.R.E.E.N Foundation	1	Increasing Screening and Health Equity in OC	9/1/24 - 8/31/26	12/24 - 2/25: Received the data from CalO on 2/7/225. 3 staff trainings conducted	$ 295,100	$ 73,775	In Progress
UCI Family Health Center	1	Closing the Cancer Screening Gap	9/1/24 - 8/31/26	12/24 - 2/25: 2,168 members served	$ 1,500,000	$ 375,000	In Progress
AltaMed	1	Comprehensive Community Cancer Program - Capacity Building (CCCP-CB)	9/1/24 - 8/31/26	12/24 - 2/25: 1,662 members served	$ 1,499,992	$ 374,998	In Progress
AltaMed (2)	1	Comprehensive Community Cancer Program - Infrastructure and Capital Improvements (CCCP-ICI)	9/1/24 - 8/31/26	Development of Compass Rose module and integration into Epic EHR completed	$ 752,349	$ 188,087.25	In Progress
					$	$	

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Board-Approved Initiative Status and Impact Summary

Report Date:	5/13/2025	**Initiative Name:**	Dyadic Services Program Academy	**Start Date:**	6/1/2024
Reporting Period:	Jan-Mar (Q3)			**End Date:**	5/31/2026
Program Status:	In Progress	**Initiative Owner:**	Carmen Katsarov	**Approved Amount:**	$1.9 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
First 5 Orange County (F5OC) will develop and provide administrative oversight of the CalOptima Health Dyadic Services Program Academy to expand dyadic services capacity. The academy's objective is to increase access to HealthySteps dyadic services for members by launching 10 sustainable dyadic services programs across Orange County. F5OC will provide pre-academy planning and development, a 9-month academy, and 12-month post-academy technical assistance for each clinic.	- Academy started on schedule and in process. - Baseline data received on participating clinics which will enable accurate outcome reporting on the key objectives.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Train 10 clinics to complete the Academy and obtain HealthySteps certification.	Number of clinics that completed the Dyadic Care Training Academy and obtained required HealthySteps certification	Academy started on schedule and still in process. Will report back when academy is completed.
Increase members receiving well child visits and screenings.	Claims/encounter data on well child visits and screenings	Academy started on schedule and still in process. Baseline data for participating clinics submitted. Will report back when academy is completed.
Increase billing for Dyadic Services and non-speciality mental health.	Claims/encounter data on dyadic services and mental health services	Academy started on schedule and still in process. Baseline data for participating clinics submitted. Will report back when academy is completed.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/12/25	**Initiative Name:**	Five-Year Hospital Quality Program	**Start Date:**	1/1/2023
Reporting Period:	Jan-Mar (Q3)			**End Date:**	12/31/2028
Program Status:	In Progress	**Initiative Owner:**	Linda Lee	**Approved Amount:**	$153.5 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Hospital Quality Program for CalOptima Health-contracted hospitals aims to improve quality of care to members through increased quality and patient safety efforts. Program goals: 1) Support hospital quality standards for Orange County; 2) Provide industry benchmarks and data-driven feedback; 3) Recognize hospitals demonstrating quality performance; 4) Provide comparative information on network hospitals; and 5) Identify areas for improvement.	CalOptima Health has been meeting with hospital CEOs to discuss options to utilize unearned hospital quality dollars. The prevailing recommendation is to roll forward unearned dollars into the next measurement year.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Reward contracted Medi-Cal hospitals for high performance on hospital quality of care, patient experience, and hospital safety using CMS hospital quality and Leapfrog patient safety measures.	The percentage of contracted hospitals earning hospital quality incentives. Metric equals number of hospitals earning any incentive amount divided by number of eligible contracted hospitals.	Hospitals are submitting MY2024 data to CMS and Leapfrog. Data will be available starting July 2025.
	The percentage of hospital quality dollars awarded. Metric equals total incentives awarded divided by total annual incentive pool.	Hospitals are submitting MY2024 data to CMS and Leapfrog. Data will be available starting July 2025.
Improve hospital quality	Star Rating	Hospitals are submitting MY2024 data to CMS and Leapfrog. Data will be available starting July 2025.
Improve hospital patient experience	Star Rating	Hospitals are submitting MY2024 data to CMS and Leapfrog. Data will be available starting July 2025.
Improve hospital patient safety	Safety Grade	Hospitals are submitting MY2024 data to CMS and Leapfrog. Data will be available starting July 2025.

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Hospital Quality Stars Rating

Hospital	Hospital Quality STARS Rating	Hospital Patient Survey Rating	Leapfrog Hospital Safety Guide	Maximum Incentive Possible	Incentive Earned
Anaheim Regional Medical Center	★★★	★★	B	$1,413,638	$494,773
Anaheim Global Medical Center	N/A	★★	C	$265,834	$26,583
Chapman Global Medical Center	★	★	D	$155,157	$0
Children's Hospital of Orange County	★★★★★	★★★★★	B	$3,598,119	$3,418,213
Foothill Regional Medical Center	N/A	★	N/A	$627,218	$0
Fountain Valley Regional Hospital & Medical Center	★★	★	D	$3,456,890	$0
Hoag Memorial Hospital Presbyterian	★★★★★	★★★★	A	$1,940,663	$1,746,597
Los Alamitos Medical Center	★	★★	D	$404,816	$0
Memorial Care Long Beach Medical Center	★★	★★★	C	$207,276	$62,183
Memorial Care Miller Children's and Women's Hospital	★★	★★★	C	$ –	$ –
Memorial Care Orange Coast Medical Center	★★★★	★★★	C	$1,120,696	$672,418
Memorial Care Saddleback Medical Center	★★★	★★★	B	$412,305	$226,768
Orange County Global Medical Center	★	★★	D	$2,013,149	$0
Placentia Linda Hospital	★★	★★★	C	$360,336	$108,101
Pomona Valley Hospital Medical Center	★★★★	★★★	A	$29,354	$20,548
Providence Mission Hospital	★★★★	★★★	B	$1,305,806	$848,774
Providence St. Joseph Hospital	★★★★	★★★★	B	$2,881,640	$2,161,230
Providence St. Jude Medical Center	★★★★	★★★	B	$1,355,978	$881,386
South Coast Global Medical Center	N/A	★	D	$359,887	$0
UCI Medical Center	★★★★	★★★★	A	$5,881,296	$4,705,037
Whittier Hospital Medical Center	★★★	★★	B	$53,167	$18,608
	TOTALS			**$27,843,225**	**$15,391,218**

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/12/2025	**Initiative Name:**	OneCare Member Health Incentives	**Start Date:**	1/1/2024
Reporting Period:	Jan-Mar (Q3)			**End Date:**	12/31/2024
Program Status:	In Progress	**Initiative Owner:**	Linda Lee	**Approved Amount:**	$500,000
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Provide health rewards and incentives to motivate members to establish primary care relationships and get recommended preventive care and screenings.	- In Jan 2025, CalOptima Health transitioned OneCare member health rewards to a digital reward instead of physical gift cards. This enables more timely issuance of gift cards to members. - From Jan to Mar 2025: Issued 6,173 member incentives, equating to $183,625. Annual Wellness Visits (1,149 rewards, $57,450); Breast Cancer Screening (38 rewards, $950); Colorectal Cancer Screening (23 rewards, $1,150); Diabetes HbA1c Test (42 rewards, $1,050); Diabetes Retinal Eye Exam (21 rewards, $525); Osteoporosis Screening (24 rewards; $600); and Health Risk Assessments (4,876 rewards, $121,900). - Identified unspent funds of $247,025 will be returned to reserves. CY2024 incentives on hand will cover remaining amounts.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Improve rate of preventive health screenings	Breast cancer screening Colorectal cancer screening Osteoporosis management for people with fractures	Q2 data in progress; available in July 2025
Improve screening rates for members with diabetes	Diabetes care: Blood sugar screening Retinal eye exams	Q2 data in progress; available in July 2025

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/12/2025	**Initiative Name:**	Quality Initiatives from Unearned P4V Program	**Start Date:**	7/1/2024
Reporting Period:	Jan-Mar (Q3)			**End Date:**	12/31/2025
Program Status:	In Progress	**Initiative Owner:**	Linda Lee	**Approved Amount:**	$23.3 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health implements an annual Pay for Value Program (P4V) to promote high quality outcomes and improvement in quality measures among Health Network and CalOptima Health Care Network (CCN) primary care physicians (PCPs). Each year providers earn a portion of allocated incentive dollars and forfeit a portion of incentive dollars by not achieving the highest benchmarks. Starting with the measurement year 2023 P4V program, the Board approved the use of unearned incentive dollars towards quality initiatives.	- OneCare grant funds were issued in Q1 2025. Grant initiation meetings were held with grant recipients to review grant expectations and reporting requirements. Semiannual grant reports will be due July 2025. - CalOptima Health staff will generate a grant recipient list as an attachment to the next quarterly report.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Stimulate improvement on lower performing quality measures by issuing grants to Health Networks and CCN PCPs for the implementation of quality improvement initiatives	Number of grant awards among Health Networks for Medi-Cal measures	17 grants were awarded to five Health Networks; totaling $2,940,120
	Number of grant awards among CCN PCPs for Medi-Cal measures	15 grants were awarded across 12 organizations totaling $2,052,492
	Number of grant awards among Health Networks for OneCare measures	5 grants were awarded to five Health Networks; totaling $1,028,628
Number of grant awards among CCN PCPs for Medi-Cal measures	(attachment)	

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Medi-Cal Quality Initiatives

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
1			CCN		HPN-Regal		OPTUM		Prospect		Family Choice		CHOC		AMVI Care		Noble		AltaMed		UCMG	
2	Clinical Measure (HEDIS)	Submeasure	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile
3	Breast Cancer Screening (BCS-E)	Non-MCR Total	58.47%	67th	58.45%	67th	51.28%	33rd	59.32%	67th	59.58%	67th	0.00%	<10th	66.52%	90th	51.14%	33rd	53.90%	33rd	55.08%	67th
4	Cervical Cancer Screening (CCS)		61.30%	67th	50.75%	10th	53.15%	10th	55.88%	33rd	61.20%	67th	4.31%	<10th	54.54%	33rd	46.03%	10th	57.85%	33rd	53.74%	33rd
5	Child and Adolexcent Well-Care Visits (WCV)	Total	47.07%	33rd	32.35%	<10th	47.69%	33rd	43.45%	10th	53.05%	67th	59.44%	67th	55.25%	67th	46.85%	33rd	41.17%	10th	51.98%	67th
6	Childhood Immunization Status (CIS)	Combo 10	29.60%	33rd	24.16%	10th	27.78%	33rd	41.08%	67th	45.58%	90th	35.64%	67th	34.98%	33rd	32.29%	33rd	41.64%	67th	57.93%	90th
7	Chlamydia Screening in Women (CHL)	Total	72.56%	90th	67.38%	67th	64.16%	67th	67.90%	90th	67.75%	90th	79.93%	90th	83.10%	90th	64.36%	67th	78.93%	90th	64.14%	67th
8	Controlling High Blood Pressure (CBP)		72.43%	90th	57.54%	10th	72.15%	67th	77.12%	90th	69.68%	67th	40.46%	<10th	93.52%	90th	84.12%	90th	82.01%	90th	61.54%	33rd
11	Hemoglobin A1c Control for Patients with Diabete	Poor Control	30.39%	67th	18.14%	90th	34.84%	33rd	37.56%	33rd	47.70%	10th	62.11%	<10th	12.81%	90th	26.50%	90th	27.00%	90th	18.12%	90th
12	Immunizations for Adolescents (IMA)	Combo 2	35.51%	33rd	23.92%	<10th	39.37%	67th	43.24%	67th	47.36%	67th	49.66%	90th	56.27%	90th	45.34%	67th	48.23%	67th	48.74%	67th
13	Lead Screening in Children (LSC)		62.71%	33rd	15.38%	<10th	55.93%	33rd	68.57%	67th	67.89%		64.75%	33rd	64.41%	33rd	64.74%	33rd	78.32%	67th	66.15%	33rd
14	Prenatal and Postpartum Care (PPC)	Postpartum	83.55%	67th	77.82%	33rd	72.62%	10th	53.04%	<10th	70.44%	10th	79.94%	33rd	70.05%	10th	64.63%	<10th	81.20%	67th	74.46%	10th
15	Prenatal and Postpartum Care (PPC)	Prenatal	92.11%	90th	85.63%	33rd	82.22%	33rd	72.54%	<10th	64.20%	<10th	82.96%	33rd	83.58%	33rd	83.50%	33rd	89.23%	67th	58.12%	<10th
16	Well-Child Visits in the First 30 Months of Life (W3	First 15 Months	53.18%	10th	50.00%	10th	60.46%	33rd	67.44%	67th	49.32%	10th	56.50%	33rd	67.02%	67th	57.14%	33rd	64.04%	67th	55.36%	33rd
17	Well-Child Visits in the First 30 Months of Life (W3	15 Months - 30 Months	70.73%	67th	54.55%	<10th	72.26%	67th	74.75%	67th	79.92%	90th	73.13%	67th	68.91%	33rd	71.25%	67th	57.89%	10th	73.86%	67th
18	Satifaction Measure (CAHPS)		Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percetile	Rate	Percetile	Rate	Percentile	Rate	Percentile
19	Adult Care Coordination (Usually + Always)		84.62%	33rd	69.77%	<10th	82.14%	10th	88.89%	67th	80.00%	10th	81.25%	10th	72.73%	<10th	78.57%	10th	83.72%	33rd	71.05%	<10th
20	Adult Customer Service (Usually + Always)		85.71%	10th	83.79%	<10th	92.22%	90th	80.57%	<10th	83.02%	<10th	78.57%	<10th	81.82%	<10th	89.95%	33rd	90.16%	33rd	84.41%	<10th
21	Adult Getting Care Quickly (Usually + Always)		79.62%	33rd	81.79%	33rd	73.12%	<10th	76.94%	10th	72.88%	<10th	73.46%	10th	66.95%	<10th	75.29%	10th	73.95%	10th	73.51%	10th
22	Adult Getting Needed Care (Usually + Always)		80.96%	33rd	80.68%	33rd	75.49%	10th	77.80%	10th	73.13%	<10th	76.42%	10th	67.69%	<10th	81.30%	33rd	81.53%	33rd	72.31%	<10th
23	Adult Rating of Health Care (9+10)		67.71%	90th	55.29%	33rd	40.91%	<10th	44.55%	<10th	53.41%	10th	56.25%	33rd	50.88%	10th	52.54%	10th	63.86%	90th	44.93%	<10th
24	Adult Rating of Health Network (9+10)		59.17%	10th	53.69%	10th	52.08%	<10th	59.56%	33rd	53.08%	10th	68.92%	90th	50.66%	<10th	59.29%	10th	60.84%	33rd	50.61%	<10th
25	Adult Rating of PCP (9+10)		75.81%	90th	63.71%	10th	66.34%	33rd	65.38%	33rd	60.51%	<10th	83.67%	90th	59.62%	<10th	77.33%	90th	68.13%	33rd	64.91%	10th
26	Adult Rating of Specialist (9+10)		62.32%	10th	63.64%	10th	59.26%	<10th	59.74%	<10th	59.04%	<10th	55.56%	<10th	60.38%	<10th	72.73%	90th	76.47%	90th	51.67%	<10th
27	CAHPS Measure		Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percetile	Rate	Percetile	Rate	Percentile	Rate	Percentile
28	Child Care Coordination (Usually + Always)		71.43%	<10th	90.00%	90th	80.77%	10th	78.57%	10th	72.00%	<10th	71.88%	<10th	60.00%	<10th	77.27%	10th	90.48%	90th	70.97%	<10th
29	Child Customer Service (Usually + Always)		86.49%	10th	89.29%	33rd	90.70%	67th	81.62%	<10th	75.00%	<10th	86.27%	10th	78.95%	<10th	89.19%	67th	87.50%	33rd	78.68%	<10th
30	Child Getting Care Quickly (Usually + Always)		75.82%	<10th	90.91%	90th	79.95%	10th	80.22%	10th	81.05%	10th	87.10%	33rd	79.41%	10th	75.75%	<10th	87.50%	33rd	81.46%	10th
31	Child Getting Needed Care (Usually + Always)		72.33%	<10th	78.24%	10th	68.45%	<10th	79.37%	10th	68.14%	<10th	75.70%	10th	71.57%	<10th	74.60%	<10th	84.45%	33rd	68.94%	<10th
32	Child Rating of Health Care (9+10)		50.00%	<10th	50.00%	10th	62.64%	10th	61.11%	<10th	53.85%	<10th	55.13%	<10th	47.62%	<10th	58.90%	<10th	59.68%	<10th	65.42%	10th
33	Child Rating of Health Network (9+10)		55.48%	<10th	59.65%	33rd	67.50%	10th	59.49%	<10th	54.05%	<10th	68.00%	10th	43.44%	<10th	65.66%	10th	68.64%	10th	52.63%	<10th
34	Child Rating of PCP (9+10)		70.69%	10th	63.41%	10th	72.00%	10th	60.95%	<10th	59.35%	<10th	70.34%	<10th	55.13%	<10th	75.00%	33rd	77.78%	33rd	69.74%	<10th
35	Child Rating of Specialist (9+10)		71.43%	33rd	62.50%	10th	77.78%	90th	72.41%	33rd	60.71%	<10th	76.47%	67th	57.89%	<10th	71.43%	33rd	76.92%	67th	52.94%	<10th

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OneCare Quality Initiatives

OneCare HEDIS Part C Measure	Submeasure	CCN		HPN-Regal		OPTUM		Prospect		AMVI Care		Family Choice		AltaMed		Noble		UCMG	
		Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile
Breast Cancer Screening (BCS-E)	MCR Total	62.64%	2Star	60.87%	2Star	68.13%	3Star	70.94%	3Star	78.00%	4Star	0.6119	2Star	76.00%	4Star	65.91%	3Star	61.78%	2Star
Colorectal Cancer Screening (COL)	50-75 years old	65.59%	3Star	75.07%	4Star	69.71%	3Star	67.27%	3Star	63.19%	3Star	0.7123	4Star	69.26%	3Star	66.70%	3Star	72.89%	4Star
Eye Exam for Patients with Diabetes (EED)	Total	73.93%	4Star	85.30%	5Star	79.04%	4Star	73.70%	4Star	85.93%	5Star	0.738	4Star	59.59%	2Star	78.57%	4Star	71.68%	3Star
Controlling High Blood Pressure (CBP)		65.84%	2Star	85.61%	5Star	75.68%	4Star	81.53%	4Star	85.40%	5Star	0.6718	2Star	83.20%	5Star	73.79%	3Star	71.72%	3Star
Hemoglobin A1c Control for Patients with Diabetes (HBD)	Poor Control	14.38%	4Star	0.00%	5Star	20.57%	3Star	27.34%	3Star	0.00%	5Star	0.0054	5Star	0.00%	5Star	34.23%	2Star	0.00%	5Star
CAHPS Measure		**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**
Adult Care Coordination (Usually + Always)		86.11%	4Star	89.86%	5Star	87.09%	5Star	87.06%	5Star	83.68%	2Star	87.58%	5Star	86.38%	4Star	86.29%	4Star	86.70%	4Star
Adult Getting Care Quickly (Usually + Always)		74.68%	2Star	75.16%	2Star	78.48%	4Star	74.72%	2Star	74.56%	2Star	76.26%	3Star	74.77%	2Star	72.08%	1Star	78.19%	4Star
Adult Getting Needed Care (Usually + Always)		81.76%	4Star	86.34%	5Star	81.54%	4Star	82.99%	4Star	78.55%	3Star	79.86%	3Star	87.15%	5Star	87.50%	5Star	78.03%	3Star
Part D Measure		**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**
Medication Adherence for Diabetes Medications (D08)		84.71%	3Star	84.40%	3Star	87.20%	3Star	84.98%	3Star	87.32%	3Star	91.08%	5Star	81.59%	2Star	73.24%	1Star	94.20%	5Star
Medication Adherence for Hypertension (D09)		84.38%	2Star	76.38%	1Star	86.71%	3Star	86.14%	3Star	89.56%	4Star	88.47%	3Star	81.58%	1Star	83.05%	2Star	91.15%	5Star
Medication Adherence for Cholesterol (D10)		83.96%	2Star	82.55%	2Star	82.27%	2Star	83.43%	2Star	83.43%	2Star	86.48%	3Star	79.10%	1Star	79.98%	1Star	86.30%	3Star
Statin Use in Persons with Diabetes (D12)		84.40%	2Star	89.96%	4Star	85.66%	2Star	87.31%	3Star	96.28%	5Star	92.50%	5Star	89.18%	4Star	91.62%	4Star	91.76%	4Star

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	05/14/2025	**Initiative Name:**	Digital Transformation Strategy	**Start Date:**	2022
Reporting Period:	Jan-Mar (Q3)			**End Date:**	2026
Program Status:	In Progress	**Initiative Owner:**	Yunkyung Kim	**Approved Amount:**	$100.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Digital Transformation Strategy to enhance overall experience for members, providers, and employees by bridging technology and business areas, improving member and provider experience, operational effectiveness, and financial performance.	- The new www.caloptima.org website went live in April. - Jiva Care Management reporting phase completed in April. - Operations and Clinical Robotic Process Automations (RPA) will finalize its initial project scope in June 2025 and completed 13 automated processes, reducing manual processes. - Provider Lifecycle Management (PLM) Credentialing and Contracting will go-live before August 2025. - Customer Relations Management (CRM) schedule has been set for September 2025. - Staff is reassessing projects that have not started and requesting an additional budget-neutral two years to continue the Digital Transformation Initiative to complete projects.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Complete Digital Transformation projects on-time and within budget	95% of projects delivered on-time and within budget	32% (9/28) of projects have completed within a 5% variance over-all on time and within budget.

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Digital Transformation Projects: Status Report

Project Title	Status	Current Annual Budget	Actual Spend
Provider Lifecycle Management (Salesforce)	In Progress	$4,100,000	$1,040,000
Jiva Platform Implementation	Closed	$3,950,000	$1,313,197
WebMD Ignite (FKA Healthwise) Implementation	In Progress	$0	$0
Jiva Findhelp Integration	In Progress	$50,000	$45,000
Content Management for Websites	Closed	$2,457,100	$1,020,938
Contract Center Telephony System Replacement (NICE)	Closed	$2,383,000	$295,482
Call Center CRM (Salesforce)	In Progress	$2,231,250	$0
Finance ERP - Crowe MS Dynamics	In Progress	$1,706,000	$108,000
Enterprise RPA	In Progress	$1,500,000	$1,132,473
HCM & Payroll - ADP Solution	In Progress	$450,000	$18,170
Internet Bandwidth Upgrade for All Sites	Closed	$603,323	$603,323
Network Bandwidth Upgrade for All Sites - Wide Area Network	Closed	$3,631,487	$3,631,487
Cohesity	Closed	$283,489	$283,489
Verisys Credentialing Verification	Closed	$105,000	$105,000
Digital Transformation Strategy (includes Strategic Governance)	Closed	$1,408,060	$1,434,655
SSRS to Power Migration (Phase 1)	Closed	$325,500	$183,300
Member Portal and App	New	$2,000,000	$0
CMS Member Pref. & Consent Mgmt. for Data Sharing	New	$75,000	$0
Web Traffic Analytics for Websites and Portals	New	$50,000	$0
Migration off SecureAuth	New	$56,500	$0
Web Based Services for Facets	New	$250,000	$184,4910
Network Operations Center Monitoring and Control System	New	$300,000	$0
Automate Computer Provision Management Resources with New Infrastructure as a Code (IaC) Technology	New	$185,000	$0
Website Auditing Tool	New	$25,000	$0
Data Strategy, Governance, and Execution	New	$2,975,000	$40,0000
File Encryption	New	$200,000	$0
RightFax Transition to the Cloud	New	$150,000	$21,956
MCG Auto Auth	New	$125,000	$0

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	5/15/2025	**Initiative Name:**	Medi-Cal Provider Rate Increases	**Start Date:**	7/1/2024
Reporting Period:	Jan-Mar (Q3)			**End Date:**	12/31/2026
Program Status:	In Progress	**Initiative Owner:**	Yunkyung Kim	**Approved Amount:**	$526.2 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Authorize the CEO to execute amendments to delegated Health Networks and specific CalOptima Health Medi-Cal FFS CCN/COD contracts that update contracted rates, effective 7/1/2024, and incorporate requirements to comply with DHCS mandated Targeted Rate Increases (TRI) and other regulatory and operational requirements, effective 1/1/2024. This initiative aims to improve quality outcomes through increased access, increased provider and member satisfaction (i.e. CAHPS measures), and decreased provider terminations due to non-market competitive rates.	1) Contract amendments fully executed and effectuated in Facets to implement rate increases. 2) Continuing to analyze provider network changes to compare network changes prior to and after 7/01/2024. 3) Analyze the 2024 Timely Access Survey and CAHPs results to determine if the initiative achieved the expected results.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Maintain and increase members' access to care.	Maintain and enhance network adequacy.	1) The quarterly update to CalOptima Health Fast Facts in the CalOptima Health Board Book completed. 2) Presented network adequacy deficiencies at the Q3 Quality Assurance Committee of the Board.
	Increase timely access to care for members.	In the process of collecting the 2024 Timely Access Survey, with results available June 2025, to help identify baseline and target.
Maintain and increase quality of care for members.	Increase quality scores through the 2024 HEDIS and Quality Scores.	Working to identify any applicable provider network gaps that were mitigated by the rate increase.
Improve provider satisfaction.	Increase provider satisfaction scores.	Continuing to identify solution to administer survey to increase response rates and achieve statistically significant results.

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Board-Approved Initiative Status and Impact Summary

Report Date:	5/13/2025	**Initiative Name:**	Skilled Nursing Facility Access Program	**Start Date:**	1/1/2023
Reporting Period:	Jan-Mar (Q3)			**End Date:**	12/31/2026
Program Status:	In Progress	**Initiative Owner:**	Dr. Zeinab Dabbah	**Approved Amount:**	$10.0 Million
Payment Status:	Not Started				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Skilled Nursing Facility (SNF) Access Program is to enhance quality through better access and further strengthen the safety net system across Orange County for individuals who require SNF post-hospitalization care.	- Identified a clear gap in what is called " Transitional Care Units " or TCU. A TCU is specifically designed as a distinct care unit, usually up to 2 weeks maximum to allow members to transition from Acute Care Hospital setting to SNF, home or assisted level. - CalOptima Health will explore leasing TCU beds located at an acute care facility of a willing partner. This will result in improvement in acute length of stay, move the members along the continuity of care, and address clinical issues that require coordination while meeting the Transition of Care goals required by DHCS.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Improve acceptance rate for TOC patients from acute setting to SNF	Reduced administrative days by 5%	TBD upon implementation of the TCU program.
Establish clinical rounds at SNFs by Q2 2025 (CY)	Established clinical rounds with SNF providers	TBD upon implementation of the TCU program.
Establish partnership meetings with contracted SNFs	Established partnership meetings	In progress
Improve provider payments for difficult-to-place members	Rate enhancement for members w/ isolation, bedside dialysis, social and behavioral obesity	Complete: The reimbursement methodology recommended by the SNF workgroup was accomplished thru rate enhancements and supplemental payments; funding from this initiative will no longer be utilized for this objective.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

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

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

Recommended Actions
1. Approve the CalOptima Health Fiscal Year 2025-26 Operating Budget and Non-Operating Items and authorize expenditures and appropriate 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. Approve the CalOptima Health Fiscal Year 2025-26 Covered California Budget, allocate up to $10.8 million from existing reserves to fund pre-implementation expenditures related to Covered California, and authorize expenditures and appropriate funds for the items in Attachment B1: Covered California Administrative Budget Details.
3. Approve the CalOptima Health Fiscal Year 2025-26 Digital Transformation Strategy Budget and authorize expenditures and appropriate funds for the items in Attachment B2: Digital Transformation Administrative Budget Details.

Background
The CalOptima Health Fiscal Year (FY) 2025-26 Budget provides revenues and appropriations for the period of July 1, 2025, through June 30, 2026, and includes the following budget categories:

- Lines of Business:
  - Medi-Cal
  - OneCare
  - Program for All-Inclusive Care for the Elderly (PACE)
  - Multipurpose Senior Services Program (MSSP)
  - Facilities
- Covered California
- Digital Transformation Strategy
- Non-Operating Items:
  - Net Investment Income
  - 500 Building
  - Street Medicine Support Center

Staff is submitting a comprehensive budget for all lines of business for approval, using assumptions based on the best information available to date. Pursuant to CalOptima Health Policies GA.3202: CalOptima Health Signature Authority, GA.5002: Purchasing, and GA.5003: Budget Approval and Budget Reallocation, the Board of Directors' approval of the budget authorizes the expenditure for the items and appropriates the funds requested without further Board of Directors (Board) action to the extent the Board has or is, as indicated in the budget attachments, delegating authority to staff.

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CalOptima Health's primary revenue source is the State of California (State). The Governor's proposed budget for FY 2025-26 released in January did not include any new spending or reductions to current programs and initiatives. However, staff anticipates the State will propose budget savings measures given the cost pressures within the Medi-Cal program caused by increased caseload, higher utilization and costs in managed care, fee-for-service and pharmacy, and higher-than-expected costs from expanding full-scope Medi-Cal coverage to undocumented individuals.

As of this writing, several policy, program, or funding changes are being considered at both the federal and State levels. The CalOptima Health FY 2025-26 Operating Budget does not include Medicaid or Medicare cost savings proposals being considered by the U.S. Congress or the State Legislature. Staff will continue to monitor legislative actions and return to the Board with further recommendations if additional resources are necessary beyond what was incorporated in this budget.

Discussion

Operating Budget: Staff proposes an Operating Budget with an operating surplus of $32.65 million or 0.70% for FY 2025-26 as summarized in the following table and details below:

FY 2025-26 Operating Budget

	Medi-Cal	OneCare	PACE	MSSP*	FY 2025-26 Budget
Average Monthly Enrollment	866,184	17,943	551	558	884,677
Revenue	$4,161,142,347	$467,699,407	$60,154,226	$2,988,648	$4,691,984,627
Medical Costs	$3,884,377,197	$441,120,700	$51,878,014	$2,725,088	$4,380,101,000
Administrative Expenses	$235,316,770	$38,351,645	$3,856,419	$1,706,971	$279,231,806
Operating Income/Loss	**$41,448,379**	**($11,772,938)**	**$4,419,793**	**($1,443,412)**	**$32,651,822**
Medical Loss Ratio (MLR)	93.35%	94.32%	86.24%	91.18%	93.35%
Administrative Loss Ratio (ALR)	5.66%	8.20%	6.41%	57.12%	5.95%

* MSSP enrollment included in Medi-Cal total.
Note: Totals may not add up due to rounding.

A previous Board action at the May 2, 2024, meeting approved provider rate increases to hospitals, community clinics, behavioral health/applied behavior analysis providers, physicians, health networks, and other ancillary providers. The budget includes approximately $210.5 million in medical costs to fund these increases in FY 2025-26.

For more information, please refer to Attachment A: Fiscal Year 2025-26 Operating Budget for All Lines of Business and Non-Operating Items.

Operating Budget Analysis

Enrollment: The budget forecasts a 3.0% decrease in combined enrollment from the previous budget year, predominantly driven by the Medi-Cal line of business. The forecast includes the continuation of normal Medi-Cal eligibility redetermination activities and a decrease primarily in the Unsatisfactory Immigration Status population of adults ages 26-49 across the course of the budget year. For CalOptima Health's Medicare enrollment, the budget forecasts a modest increase from the prior budget year of

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approximately 3.2%. In PACE, the forecast includes an 8.4% increase primarily driven by an expected increase in enrollment at Alternative Care Setting centers.

Revenue: The budget projects revenue for each line of business based on the most recent capitation rates available from the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS). Staff made additional adjustments based on member acuity and included trend assumptions based on CalOptima Health's Rate Development Template submission to DHCS. The FY 2025-26 Operating Budget revenue on a per member per month basis is nearly the same as the prior year's funding. This assumption is informed by increasing service category medical trends, offset by mounting State budgetary pressures.

Medical Costs: The budget proposes a 93.35% MLR. The budget accounted for forecasted provider capitation payments, professional, facility, ancillary, managed long-term services and supports, prescription drugs, medical management, CalAIM, and other medical costs. The budget:

- Calculates trends based on historical experience;
- Incorporates risk arrangement changes anticipated in the budget year;
- Includes provider rate increases committed by the Board on May 2, 2024;
- Continues to apply Targeted Rate Increases Phase I for contracted providers who render primary care or general care, as defined in DHCS guidance; and
- Continues CalAIM Community Supports services.

Several methods were utilized to develop the medical cost forecasts. Predominantly, projections were based on trends calculated from historical experience. Historical experience included several years' worth of data to calculate appropriate trends. Staff assigned various credibility to the different time periods depending on how representative they were of expected future utilization. In addition, adjustments were applied to account for known changes to operations, program structure, benefits, and regulatory policies. Staff used historical data, proxy data, and industry benchmarks, where available, and checked the results for reasonability.

Administrative Expenses: The budget proposes a 5.95% ALR, which is similar to the prior year Board-approved ALR of 5.87% (including Board-approved adjustments). The primary drivers for the higher administrative expenses in the budget are:

- Personnel costs, including addition of essential positions to support operations, an annual merit increase of 3.5%, employee benefit premium increases, and continuation of certain employee supplemental benefits; and
- Non-salary expenses, including expenses to comply with mandated program requirements and technology updates to support business changes.

Staff prepared the General and Administrative budget using a "zero-based" budgeting methodology, which required departments to justify each expense before adding it to the budget. Attachment B: Administrative Budget Details provides additional information regarding all administrative expenses included in the FY 2025-26 Operating Budget.

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Covered California
With the approved change to CalOptima Health's county ordinance, staff anticipates that the new Covered California line of business will become operational on January 1, 2027. The budget includes $10.8 million in operating costs to begin preparations for the launch, including $4.2 million in Salaries, Wages & Benefits and $6.5 million in Other Operating Expenses. Staff requests an allocation of this amount from existing reserves to fund the budget through June 30, 2026. Attachment B1: Covered California Administrative Budget Details provides additional information.

Digital Transformation Strategy
On March 17, 2022, the Board authorized a three-year Digital Transformation and Workplace Modernization Strategy and created a $100 million restricted reserve to fund digital transformation efforts. The budget includes $5.2 million in operating costs to continue implementation. Attachment B2: Digital Transformation Administrative Budget Details provides additional information regarding operating expenses to continue implementation of the strategy. Staff has requested through a separate Board action an extension of the Digital Transformation Strategy through June 30, 2027, to complete existing capital projects for years one through three and implement the proposed new capital projects in year four.

Non-Operating
Net Investment Income: The budget projects $100 million in net investment income, which is based on projected market conditions and returns on investments in FY 2025-26.

500 Building: Based on the projected revenue and estimated depreciation costs, the budget projects an estimated net cost of approximately $1,156,469.

Street Medicine Support Center: The budget projects an estimated net cost of $506,847 to support preparation activities for preconstruction services and other building related activities.

Status of Total Assets and Reserve Levels
As of March 31, 2025, CalOptima Health's total net assets were $2.7 billion. Of this amount, $1.1 billion was in Board-designated reserves, $130.3 million in statutory designated reserves, $100.3 million in capital assets, $810.7 million in unspent resources committed by the Board, and $548.3 million was unallocated resources.

Since 2015, the Board has committed $1.4 billion to community outreach and investments, quality incentive programs, and infrastructure and capacity building. Many of these initiatives are multi-year commitments. As of March 31, 2025, $611.8 million has been spent; the unspent balance of allocated resources was $442.4 million; and the unspent balance of Board-approved provider rate increases (approved at the May 2, 2024, Board meeting) was $368.3 million.

At the April 3, 2025, meeting, the Board approved a modification to CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds, to increase reserve levels from a range of 2.5 to 3.0 times the monthly consolidated revenue to a range of 2.5 to 4.0 times the monthly consolidated revenue. In April, a transfer of $460 million from the Short-Term Operating accounts to the Board-designated

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Reserve Fund (Tier One) accounts was completed, increasing the reserve level to approximately 3.8 times the monthly consolidated revenue.

Fiscal Impact

Routine Operating Budget: As outlined above and described in Attachment A: Fiscal Year 2025-26 Operating Budget for All Lines of Business and Non-Operating Items, the FY 2025-26 Operating Budget projects a surplus of $32.65 million.

Covered California: The fiscal impact for the Covered California Operating Budget is $10.8 million. An allocation of up to $10.8 million from existing reserves will fund the budget through June 30, 2026.

Digital Transformation: A previous Board action on March 17, 2022, established a restricted Digital Transformation and Workplace Modernization Reserve in the amount of $100 million. An appropriation of $5.2 million from the restricted reserve will fund the non-salary operating expenses for the Digital Transformation Strategy in FY 2025-26.

Non-Operating Items: The fiscal impact for non-operating items results in a net income of $98.3 million.

Rationale for Recommendation

Staff submits the FY 2025-26 Operating Budget for all lines of business areas and non-operating items using the best information available to provide covered services to CalOptima Health's forecasted enrollment.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt
Board of Directors' Finance and Audit Committee

Attachments

1. Fiscal Year 2025-26 Operating Budget Presentation
2. Attachment A: Fiscal Year 2025-26 Operating Budget for All Lines of Business and Non-Operating Items
3. Attachment B: Administrative Budget Details
4. Attachment B1: Covered California Administrative Budget Details
5. Attachment B2: Digital Transformation Administrative Budget Details

/s/ Michael Hunn *05/30/2025*
Authorized Signature **Date**

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Fiscal Year 2025-26 Operating Budget

Board of Directors Meeting

June 5, 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.

Agenda

- Executive Summary
- FY 2025-26 Budget Overview
  - Operating Budget
    - Enrollment
    - Revenue
    - Medical Costs
    - Administrative Expenses
  - Covered California
  - Digital Transformation Strategy
  - Non-Operating Items
- Recommended Actions
- Appendix
  - FY 2025-26 Operating Budget by Lines of Business
  - Net Asset and Reserve Policy Update

Executive Summary

Potential Policy, Program or Funding Changes

- Federal
  - Medicaid work requirements
  - Limitation on state taxes on health care providers (e.g., MCO tax)
  - Immigration policy (e.g., UIS population)
  - Adjustments to Federal Medical Assistance Percentage (FMAP)
- State
  - Changes in Medi-Cal eligibility expansion to undocumented individuals
  - Delays or changes to new or existing programs
  - Limitations on the scope or amount of optional benefits
  - Managed care capitation rate adjustments

Note: Items could impact Enrollment and/or Revenue

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Overall Approach to the Budget

- Budget does not include proposals currently being considered at the federal and state levels that may impact the Medicaid program
- Current budget proposal was developed using the best finalized information available
- In the event of any material policy, program or funding changes, management will recommend budget revisions to the Board for consideration

Budget Objectives



FY 2025-26 Operating Budget:
REVENUE

$4,691,984,627

FY 2025-26 Operating Budget:
EXPENSES

$4,659,332,806

FY 2025-26 Operating Budget:
OPERATING MARGIN

$32,651,822

Operating Budget Highlights

FY 2025-26 Operating Budget	
Average Enrollment	884,677
Revenue	$4,691,984,627
Medical Costs	$4,380,101,000
Medical Loss Ratio (MLR)	*93.35%*
Administrative Expenses	$279,231,806
Admin Loss Ratio (ALR)	*5.95%*
Operating Income/Loss	**$32,651,822 or 0.70%**



CalOptima Health allocates 93 cents of every dollar received on member care

FY 2025-26 Operating Budget Overview

FY 2025-26 Budget vs. FY 2024-25 Budget

	FY 2024-25 Budget*	FY 2025-26 Budget	FY 2025-26 vs. FY 2024-25 Budget
Average Monthly Enrollment	901,163	884,677	(16,485)
Revenue	$4,292,620,541	$4,691,984,627	$399,364,086
Medical Costs	$4,253,976,649	$4,380,101,000	$126,124,351
Administrative Expenses	$251,796,061	$279,231,806	$27,435,745
Operating Income/Loss	**$(213,152,169)**	**$32,651,822**	**$245,803,991**
MLR	*99.10%*	*93.35%*	*(5.75%)*
ALR	*5.87%*	*5.95%*	*0.09%*

* Includes Board actions and budget adjustments, annualized as of March 2025

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BOARD

FY 2025-26 Budget vs. 2024-25 Actual

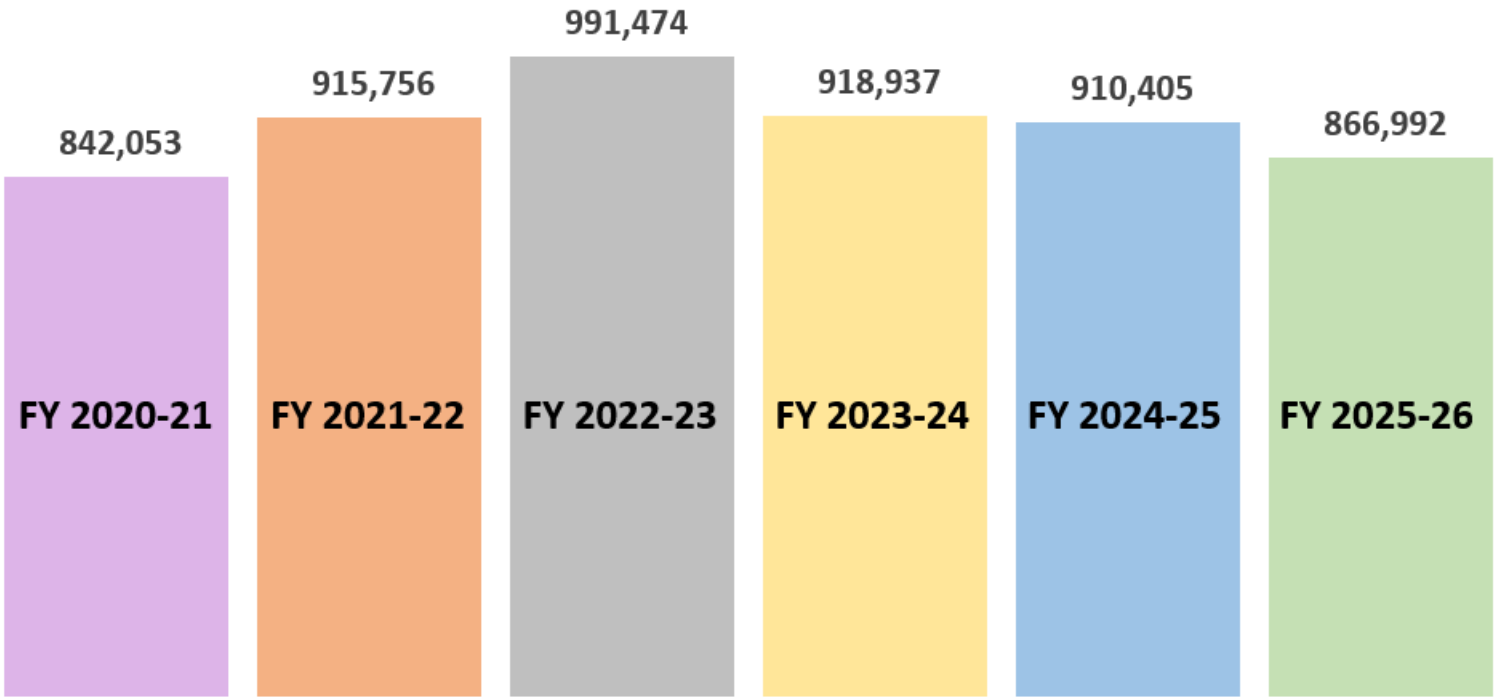
	FY 2024-25 Actual*	FY 2025-26 Budget	FY 2025-26 Budget vs. FY 2024-25 Actual
Average Monthly Enrollment	912,672	884,677	(27,995)
Revenue	$5,161,122,090	$4,691,984,627	($469,137,463)
Medical Costs	$4,754,399,325	$4,380,101,000	($374,298,325)
Administrative Expenses	$221,383,009	$279,231,806	$57,848,797
Operating Income/Loss	**$185,339,757**	**$32,651,822**	**($152,687,935)**
MLR	*92.12%*	*93.35%*	*1.23%*
ALR	*4.29%*	*5.95%*	*1.66%*

* Includes Board actions and budget adjustments, annualized as of March 2025

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Enrollment

Consolidated June Enrollment: Actuals to Forecast



- Forecasted enrollment decrease of about 44,000 or (4.8%) from June 2025 to June 2026

Enrollment Projections: Average Member Months

LOB	FY 2023-24	FY 2024-25*	FY 2025-26 Budget	FY 2025-26 Budget vs. FY 2024-25 Actual
Medi-Cal	933,229	893,963	**866,184**	(27,779)
OneCare	17,499	17,385	**17,943**	558
PACE	456	509	**551**	43
Total:	**951,184**	**911,857**	**884,677**	**(27,179)**

- Assumes no significant changes in policy:
  - Historical trends are informing future forecast
  - Continued effects of Medi-Cal eligibility redetermination activities

* Forecast based on actuals through February 2025

Note: Rounding may impact calculations

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Revenue

Revenue: Key Assumptions

- Medi-Cal
  - Based on a combination of Calendar Year (CY) 2025 Draft Rates and Forecasted CY 2026 Anticipated Rates
    - Assumes a flat revenue trend for CY 2024-25 to CY 2025-26
    - Projected CY 2026 Trends informed by the DHCS Rate Development Template (RDT) submission
  - Rates stratified by Category of Aid (COA) and Immigration Status
- OneCare
  - Based on a combination of CY 2025 and CY 2026 Medicare Part C and Part D base rates as informed by CMS communications
  - Risk scores based on actual diagnostic experience, model updates, and expected trends
- PACE
  - Rates forecasted by eligibility status from both DHCS and CMS
  - Informed by a combination of CMS publications, PACE RDT, and CMS Part D bid submission

Medical Costs

Medical Costs:
FY 2024-25 Budget vs. FY 2025-26 Budget

	FY 2024-25 Budget*	FY 2025-26 Budget	FY 2025-26 vs. FY 2024-25 Budget
Revenue	**$4,292,620,541**	**$4,691,984,627**	**$399,364,086**
Provider Capitation	$1,531,451,705	$1,537,102,362	$5,650,657
Professional, Facility & Ancillary Claims	$1,583,797,111	$1,786,905,495	$203,108,384
Managed Long-Term Services and Supports (MLTSS)	$588,084,514	$598,494,795	$10,410,281
Prescription Drugs	$113,972,885	$137,226,393	$23,253,508
CalAIM & Other Medical	$292,197,263	$148,199,026	($143,998,237)
Medical Management	$144,473,173	$172,172,928	$27,699,755
Total Medical Costs	**$4,253,976,649**	**$4,380,101,000**	**$126,124,351**
MLR	**99.10%**	**93.35%**	**(5.75%)**

* Includes Board actions and budget adjustments, annualized as of March 2025

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Medical Costs:
FY 2024-25 Actual vs. FY 2025-26 Budget

	FY 2024-25 Actual*	FY 2025-26 Budget	FY 2025-26 Budget vs. FY 2024-25 Actual
Revenue	**$5,161,122,090**	**$4,691,984,627**	**($469,137,463)**
Provider Capitation	$1,545,325,713	$1,537,102,362	($8,223,351)
Professional, Facility & Ancillary Claims	$1,651,051,757	$1,786,905,495	$135,853,738
Managed Long-Term Services and Supports (MLTSS)	$583,751,047	$598,494,795	$14,743,748
Prescription Drugs	$112,889,139	$137,226,393	$24,337,254
CalAIM & Other Medical	$733,920,925	$148,199,026	($585,721,899)
Medical Management	$127,460,744	$172,172,928	$44,712,184
Total Medical Costs	**$4,754,399,325**	**$4,380,101,000**	**($374,298,325)**
MLR	**92.12%**	**93.35%**	**1.23%**

* Includes Board actions and budget adjustments, annualized as of March 2025

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Medical Costs: Key Assumptions

- Calculates trends based on historical experience
- Incorporates risk arrangement changes anticipated in the budget year
- Includes provider rate increases committed by the Board on May 2, 2024
- Continues to apply targeted rate increases (TRI) Phase I for contracted providers who render primary care or general care as defined in DHCS guidance
- Continues CalAIM Community Support services

Administrative Expenses

Administrative Expenses: FY 2024-25 Budget vs. FY 2025-26 Budget

	FY 2024-25 Budget*	FY 2025-26 Budget	FY 2025-26 vs. FY 2024-25 Budget
Revenue	$4,292,620,541	$4,691,984,627	$399,364,086
Salaries, Wages & Benefits	**$154,862,084**	**$166,623,816**	**$11,761,732**
Non-Salary Expenses: Operating	**$86,245,372**	**$99,438,358**	**$13,192,986**
Professional Fees	$13,896,040	$13,308,490	($587,550)
Purchased Services	$23,617,387	$24,997,380	$1,379,993
Printing & Postage	$8,924,515	$7,235,448	($1,689,067)
Other Operating Expenses	$39,807,430	$53,897,040	$14,089,610
Non-Salary Expenses: Other	**$10,688,605**	**$13,169,632**	**$2,481,027**
Depreciation & Amortization	$11,154,505	$13,691,724	$2,537,219
Indirect Cost Allocation, Occupancy	(465,900)	($522,092)	($56,192)
Total Administrative Expenses	**$251,796,061**	**$279,231,806**	**$27,435,745**
ALR	**5.87%**	**5.95%**	**0.09%**

* Includes Board actions and budget adjustments, annualized as of March 2025

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Administrative Expenses: FY 2024-25 Actual vs. FY 2025-26 Budget

	FY 2024-25 Actual*	FY 2025-26 Budget	FY 2025-26 Budget vs. FY 2024-25 Actual
Revenue	$5,161,122,090	$4,691,984,627	($469,137,463)
Salaries, Wages & Benefits	**$146,224,989**	**$166,623,816**	**$20,398,827**
Non-Salary Expenses: Operating	**$65,625,338**	**$99,438,358**	**$33,813,020**
Professional Fees	$10,267,104	$13,308,490	$3,041,386
Purchased Services	$19,985,240	$24,997,380	$5,012,140
Printing & Postage	$5,930,703	$7,235,448	$1,304,745
Other Operating Expenses	$29,442,291	$53,897,040	$24,454,749
Non-Salary Expenses: Other	**$9,532,682**	**$13,169,632**	**$3,636,950**
Depreciation & Amortization	$10,465,547	$13,691,724	$3,226,177
Indirect Cost Allocation, Occupancy	($932,865)	($522,092)	$410,773
Total Administrative Expenses	**$221,383,009**	**$279,231,806**	**$57,848,797**
ALR	**4.29%**	**5.95%**	**1.66%**

* Includes Board actions and budget adjustments, annualized as of March 2025

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Administrative Budget: Bridge for FY 2024-25 Actual vs. FY 2025-26 Budget

G&A Expense	Bridge	Key Drivers
Salaries, Wages & Benefits	**$20.4M**	• New and Open Positions: $6.8M • Transition of Information Technology labor resources from DTS: $7.4M • Annual merit increase: $3.7M • Employee benefits adjustments: $2.5M
Non-Salary Expenses: Operating		
Professional Fees	**$3.0M**	• Consulting for new and ongoing initiatives and software applications • Actuarial, Human Resources, and Real Estate consulting support • Strategic plan development and implementation
Purchased Services	**$5.0M**	• Information technology support services • Broker agency commission for member enrollment • Member interpretation and translation • Claims prepayment editing and coordination of benefits
Printing & Postage	**$1.3M**	• Mailing and processing of member packages and notices
Other Operating Expenses	**$24.5M**	• Transition of DTS software licenses and maintenance support • Software licenses and maintenance agreements • Building maintenance and supplies
Non-Salary Expenses: Other		
Depreciation & Occupancy	**$3.6M**	• Capital items placed in service
Total G&A	**$57.8M**	

Note: Totals may not add due to rounding

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Covered California

Covered California Operating Budget

	FY 2025-26 Budget
Salaries, Wages & Employee Benefits	$4,241,779
Professional Fees	$5,380,000
Purchased Services	$624,000
Printing and Other Operating Expenses	$518,900
Total:	**$10,764,679**

- Anticipated start date: January 1, 2027
- Budget addresses operating costs to prepare for launch

Digital Transformation Strategy

DTS Year Four Operating Budget

	FY 2025-26 Budget
Professional Fees	$3,000,000
Other Operating Expenses	$2,187,500
Total:	**$5,187,500**

- March 17, 2022: Board authorized a three-year strategy and created a $100 million restricted reserve to fund digital transformation efforts
- Please refer to DTS funding summary provided in the FY 2025-26 Capital Budget materials

Non-Operating Items

Non-Operating Budget

	FY 2025-26 Budget
500 Building	
Annual Revenue	$1,418,466
Estimated Operating Expenses	$2,574,935
Net Change:	**($1,156,469)**
Street Medicine Support Center	
Estimated Operating Expenses	$506,847
Net Change:	**($506,847)**
Investment Income	
Total Investment Income:	**$100,000,000**
Total Non-Operating:	**$98,336,684**

- Building expenses are treated as non-operating for FY 2025-26

Attachment A: Consolidated Income Statement

Attachment A: Fiscal Year 2025-26 Operating Budget for All Lines of Business and Non-Operating Items

	Medi-Cal	OneCare	PACE	MSSP	Facilities	Consolidated
Member Months	10,394,204	215,313	6,612	6,696	-	**10,616,129**
Avg Members	866,184	17,943	551	558	-	**884,677**
Revenue						
Capitation Revenue	$ 4,161,142,347	$ 467,699,407	$ 60,154,226	$ 2,988,648	$ -	$ **4,691,984,627**
Total	$ 4,161,142,347	$ 467,699,407	$ 60,154,226	$ 2,988,648	$ -	$ **4,691,984,627**
Medical Costs						
Provider Capitation	$ 1,337,726,855	$ 199,375,507	$ -	$ -	$ -	$ **1,537,102,362**
Professional, Facility & Ancillary Claims	$ 1,680,673,393	$ 86,333,433	$ 19,898,669	$ -	$ -	$ **1,786,905,495**
Managed Long-Term Services and Supports (MLTSS)	$ 597,571,457	$ -	$ 527,852	$ 395,487	$ -	$ **598,494,795**
Prescription Drugs	$ -	$ 128,351,163	$ 8,875,230	$ -	$ -	$ **137,226,393**
CalAIM & Other Medical	$ 135,707,207	$ 8,972,139	$ 3,519,679	$ -	$ -	$ **148,199,026**
Medical Management	$ 132,698,285	$ 18,088,457	$ 19,056,585	$ 2,329,601	$ -	$ **172,172,928**
Total	$ 3,884,377,197	$ 441,120,700	$ 51,878,014	$ 2,725,088	$ -	$ **4,380,101,000**
MLR	*93.35%*	*94.32%*	*86.24%*	*91.18%*		*93.35%*
Gross Margin	$ 276,765,150	$ 26,578,707	$ 8,276,211	$ 263,560	$ -	$ **311,883,628**
Administrative Expenses						
Salaries, Wages, & Employee Benefits	$ 148,352,599	$ 14,546,479	$ 2,229,017	$ 1,495,721	$ -	$ **166,623,816**
Non-Salary Operating Expenses	$ 84,488,130	$ 9,427,166	$ 1,398,017	$ 120,250	$ 4,004,795	$ **99,438,358**
Depreciation & Amortization	$ 11,372,543	$ -	$ 19,465	$ -	$ 2,299,716	$ **13,691,724**
Indirect Cost Allocation, Occupancy Expense	$ (8,896,501)	$ 14,378,000	$ 209,920	$ 91,000	$ (6,304,511)	$ **(522,092)**
Total	$ 235,316,770	$ 38,351,645	$ 3,856,419	$ 1,706,971	$ -	$ **279,231,806**
ALR	*5.66%*	*8.20%*	*6.41%*	*57.12%*		*5.95%*
Operating Income/(Loss) Excluding Provider Rate Increases	$ **41,448,379**	$ **(11,772,938)**	$ **4,419,793**	$ **(1,443,412)**	$ -	$ **32,651,822**
						0.70%
Covered California						$ **(10,764,679)**
Digital Transformation Strategy						$ **(5,187,500)**
Non-Operating						
Net Investment Income						$ **100,000,000**
500 Building						$ **(1,156,469)**
Street Medicine Support Center						$ **(506,847)**
Total Non-Operating Income/(Loss)						$ **98,336,684**

Recommended Actions

- Approve the CalOptima Health Fiscal Year 2025-26 Operating Budget and Non-Operating Items and authorize expenditures and appropriate 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
- Approve the CalOptima Health Fiscal Year 2025-26 Covered California Budget, allocate up to $10.8 million from existing reserves to fund pre-implementation expenditures related to Covered California, and authorize expenditures and appropriate funds for the items in Attachment B1: Covered California Administrative Budget Details
- Approve the CalOptima Health Fiscal Year 2025-26 Digital Transformation Strategy Budget and authorize expenditures and appropriate funds for the items in Attachment B2: Digital Transformation Administrative Budget Details

Appendix:
FY 2025-26 Operating Budget by Line of Business

Medi-Cal

Medi-Cal Budget

	FY 2023-24 Actual	FY 2024-25 Actual*	FY 2025-26 Budget
Average Monthly Enrollment	932,770	894,961	886,184
Revenue	$4,914,889,038	$4,688,051,155	$4,161,142,347
Medical Costs	$4,096,026,098	$4,332,840,825	$3,884,377,197
Administrative Expenses	$169,028,448	$183,080,510	$235,316,770
Operating Income/Loss	**$649,834,491**	**$172,129,820**	**$41,448,379**
MLR	83.34%	92.42%	93.35%
ALR	3.44%	3.91%	5.66%

* Includes Board actions and budget adjustments, annualized as of March 2025

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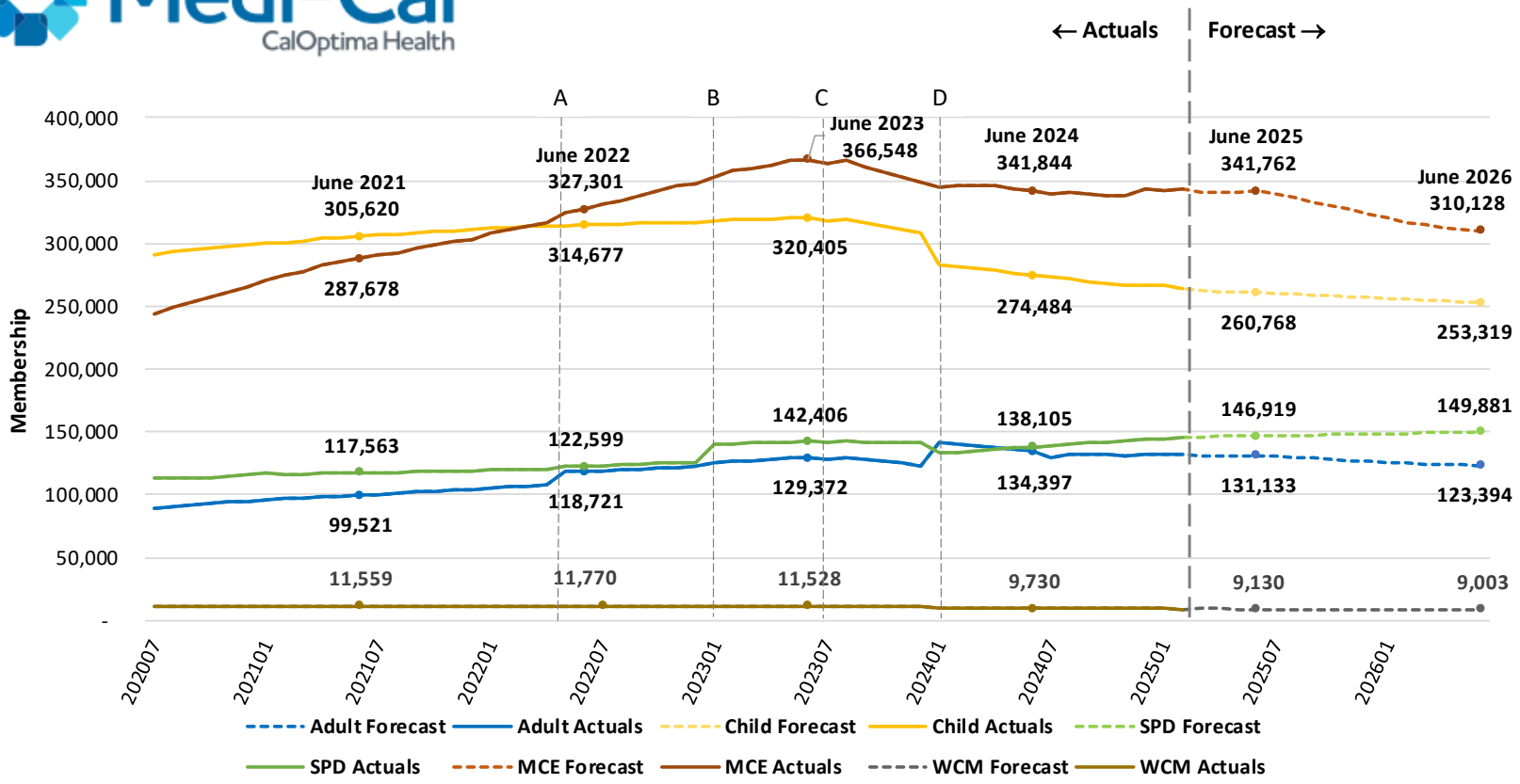
CalOptima Health

BOARD

Medi-Cal Enrollment: Trend and Forecast

Medi-Cal
CalOptima Health

By COA



A. May 2022 - Undoc. Adults Age 50+ (17K)
B. January 2023 - OCC enrollment moves to OC and MC (Duals)
C. July 2023 - Redetermination Begins
D. January 2024 - Undoc. Adults Age 26-49 (+45K) and Kaiser Transition (-55K) Asset Test Elimination For Medi-Cal Programs

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BOARD

Medi-Cal Revenue: Estimated Breakdown by Category

	Average Enrollment	Funding Source (Est. in Billion)		Total Medi-Cal Revenue
		Federal	State	
Total	**866,000**	**2.50**	**1.66**	**4.16**
UIS*	145,000	0.31	0.57	0.88
SIS	721,000	2.19	1.09	3.28
Percent of Total		*60%*	*40%*	*100%*

- Approximately 90% of UIS population are 19 years or older
- Estimates include base revenue only

UIS: Unsatisfactory Immigration Status

SIS: Satisfactory Immigration Status

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Medi-Cal Budget Assumptions

- Projects a 3.1% year-over-year reduction in average members compared to FY 2024-25 forecasted actuals

- Medi-Cal revenue estimated trends are informed in part by the DHCS RDT submission process

July – Dec 2025	Jan – June 2026
DHCS Calendar Year (CY) 2025 Draft Rates	DHCS Draft CY 2026 rates expected in October 2025 • 0.0% increase to Medi-Cal Classic, Expansion and Whole Child Model

- Total medical expense PMPM forecasted an increase after considering population mix, associated utilization, and unit cost trends

OneCare

OneCare Budget

	FY 2023-24 Actual	FY 2024-25 Actual*	FY 2025-26 Budget
Average Monthly Enrollment	17,488	17,209	17,943
Revenue	$408,847,800	$416,904,550	$467,699,407
Medical Costs	$371,244,593	$377,450,077	$441,120,700
Administrative Expenses	$28,265,866	$33,642,635	$38,351,645
Operating Income/Loss	**$9,337,321**	**$5,811,839**	**($11,772,938)**
MLR	90.80%	90.54%	94.32%
ALR	6.91%	8.07%	8.20%

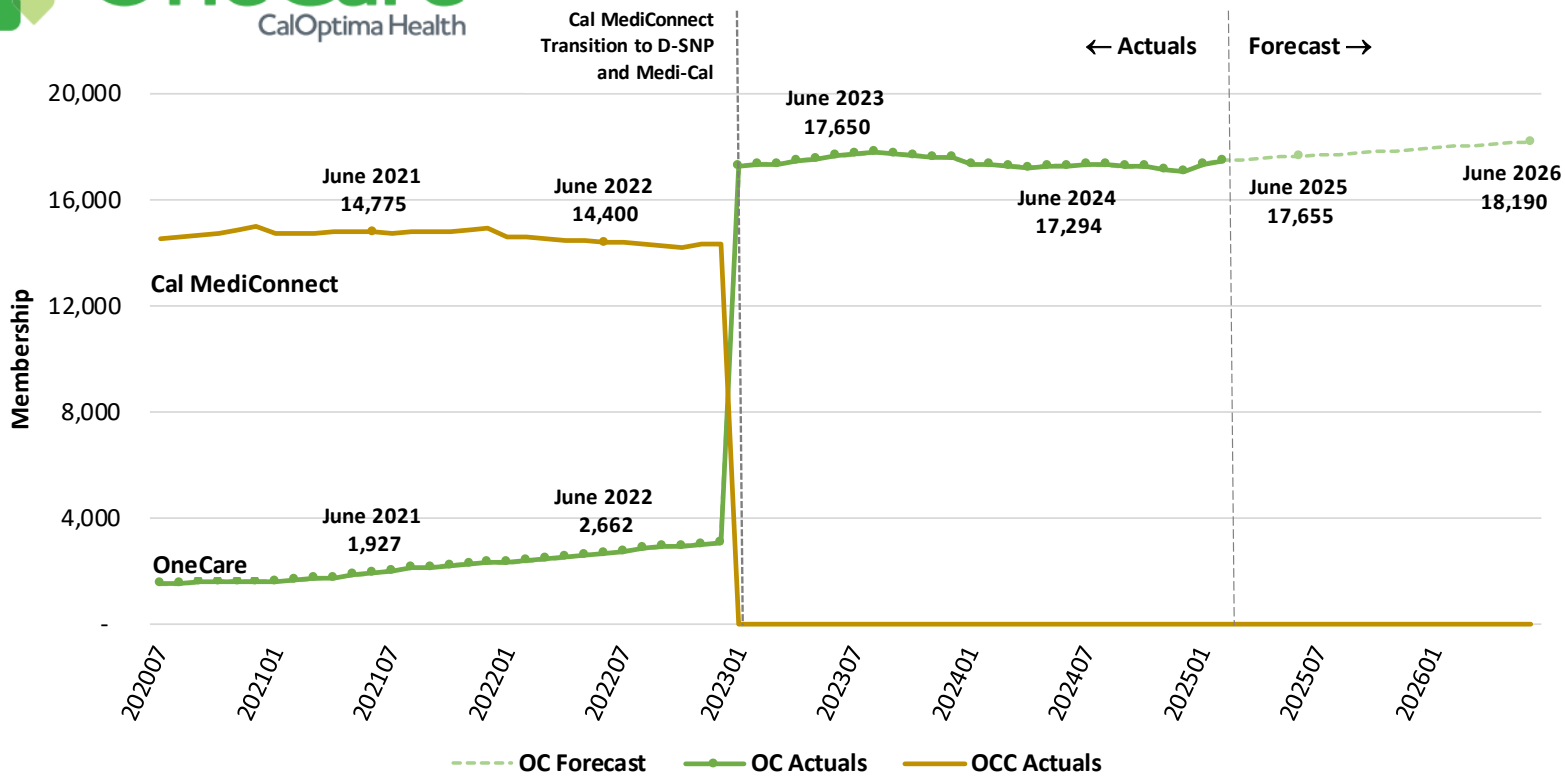
* Includes Board actions and budget adjustments, annualized as of March 2025

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BOARD

OneCare Enrollment: Trend and Forecast



OneCare Budget Assumptions

- Enrollment projected to increase by 3.2% compared to FY 2024-25 forecasted actuals
- OneCare revenue forecasted with an approximate 8.0% increase in PMPM driven primarily by Part C base rate and risk score
  - CalOptima Health will continue to receive and absorb a 2.0% sequestration reduction

July – Dec 2025	Jan – June 2026
CMS CY 2025 Part C and Part D base rates	• CMS CY 2026 Part C and Part D: Base rates projected to increase 7.7% based on CMS forecasts • Part C risk score projected relatively flat • Part D risk projected at 5.8% increase in part due to CY 2025 model change • New Part D Manufacturer Discount Program

- Medical Costs
  - Uses current capitation percent of premium (POP) rates
  - Includes expenses for approved supplemental benefits

OneCare Program Improvement Opportunities

- Plan Design
  - Continue offering a competitive benefit design that appeals to the needs of dual eligible beneficiaries in Orange County
- Marketing and Enrollment
  - Expand marketing and education to highlight the benefits of OneCare as a Medicare and Medi-Cal Exclusively Aligned Enrollment (EAE) Dual Special Needs Plan (D-SNP)
  - Promote enrollment growth by educating brokers on new enrollment rules applicable to EAE D-SNP plans
- Internal Operations
  - Currently implementing robust clinical and operational practices to improve efficiency, accuracy and quality (Star Ratings)
  - Improve data submission processes to accurately reflect diagnoses for Risk Adjustment Factors

PACE

PACE Budget

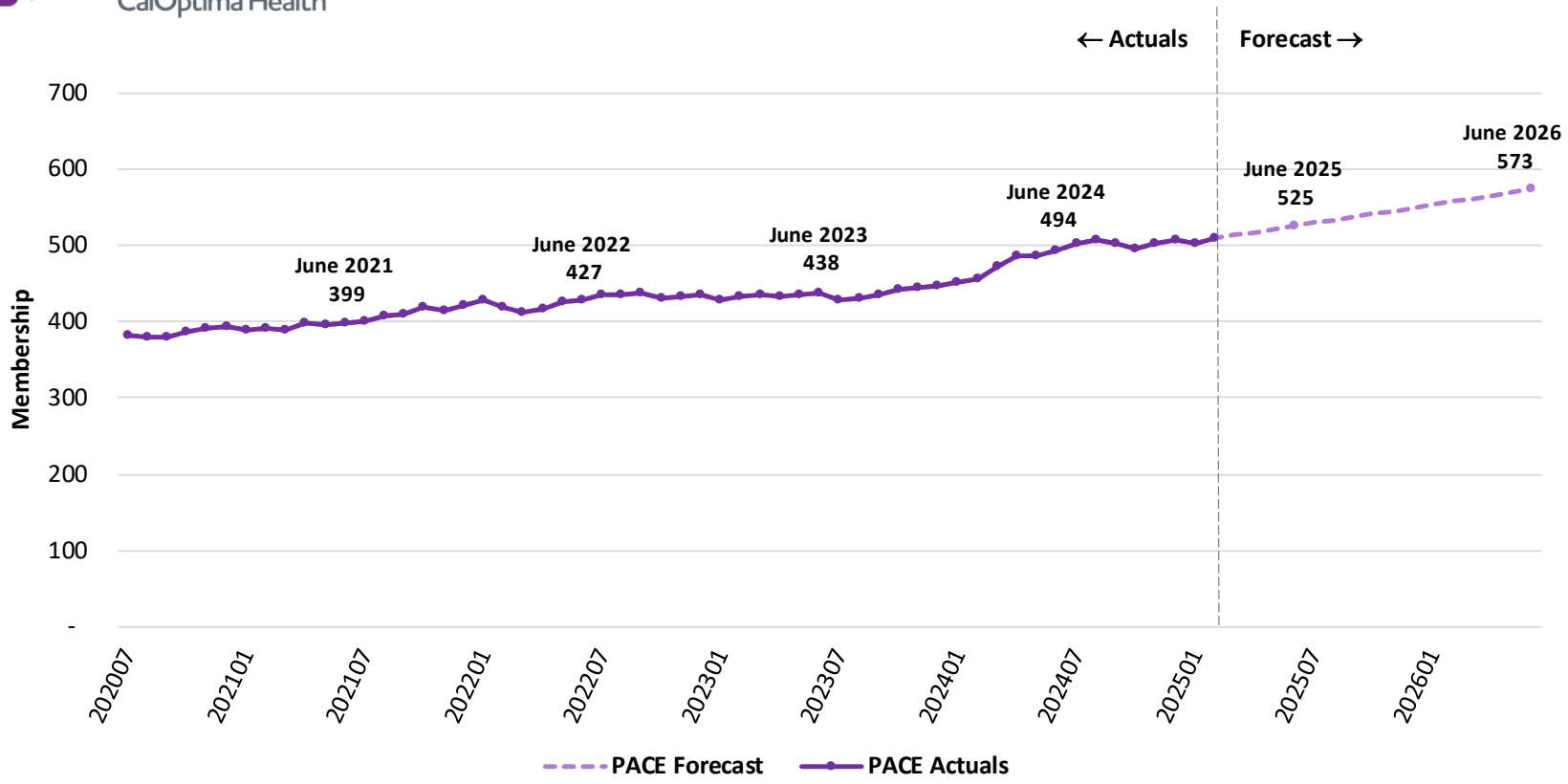
	FY 2023-24 Actual	FY 2024-25 Actual*	FY 2025-26 Budget
Average Monthly Enrollment	457	503	551
Revenue	$47,473,870	$53,368,254	$60,154,226
Medical Costs	$39,737,377	$41,428,734	$51,878,014
Administrative Expenses	$2,728,177	$3,235,482	$3,856,419
Operating Income/Loss	**$5,008,316**	**$8,704,039**	**$4,419,793**
MLR	83.70%	77.63%	86.24%
ALR	5.75%	6.06%	6.41%

* Includes Board actions and budget adjustments, annualized as of March 2025

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PACE Enrollment: Trend and Forecast

PACE
CalOptima Health



PACE Budget Assumptions

- PACE revenue rate assumptions

July – Dec 2025	Jan – June 2026
• DHCS CY 2025 Draft Rates (+4.3% Dual, +10.4% Non-dual) • CMS CY 2025 Part C and Part D base rates	• DHCS Medi-Cal Revenue: Relatively flat; Duals rate decrease of 0.5% and non-Duals rate increase of 1.7% • CMS Part C Revenue: Estimating an increase of 10% driven base rate increase of 7.7% and risk scores • New Part D Manufacturer Discount Program

- Operating costs
  - Forecasted increase due to membership and unit cost increases; medical management and administrative expenses are the main drivers of medical and operational costs
  - Assumes growth in members who receive services at alternative care settings (ACS)

PACE Improvement Opportunities

- Implement a new electronic medical record system to improve efficiency, encounter data collection and quality
- Improve operational efficiencies and expand network contracted specialist providers
- Expand member access to PACE services by utilizing culturally and linguistically competent ACS centers
- Contract with community-based providers for qualified PACE participants who want to keep their primary care doctors

Net Asset and Reserve Policy Update

Reserve Summary (as of April 2025)

	Amount (in millions)
Statutory and Board Designated Reserves	$1,706.1
Capital Assets (Net of Depreciation)	$100.3
Resources Committed by the Board	$788.4
Unallocated Resources	$130.0
Total Net Assets	**$2,724.7**

Reserve Policy (GA.3001) Revision

- 4/3/25: Board approved the modification to Policy GA.3001: Statutory and Board-Designated Reserve Funds

Board-designated Reserves at 2.5 to **3.0** months of capitation	→	Board-designated Reserves at 2.5 to **4.0** months of capitation

- As of 4/30/25, the Board-designated reserve level was 3.86 months of capitation
  - Transfer of $460 million from Operating to Tier 1 Account completed in April

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Attachment A: Fiscal Year 2025-26 Operating Budget for All Lines of Business and Non-Operating Items

	Medi-Cal	OneCare	PACE	MSSP	Facilities	Consolidated
Member Months	10,394,204	215,313	6,612	6,696	-	**10,616,129**
Avg Members	866,184	17,943	551	558	-	**884,677**
Revenue						
Capitation Revenue	$ 4,161,142,347	$ 467,699,407	$ 60,154,226	$ 2,988,648	$ -	**$ 4,691,984,627**
Total	$ 4,161,142,347	$ 467,699,407	$ 60,154,226	$ 2,988,648	$ -	**$ 4,691,984,627**
Medical Costs						
Provider Capitation	$ 1,337,726,855	$ 199,375,507	$ -	$ -	$ -	**$ 1,537,102,362**
Professional, Facility & Ancillary Claims	$ 1,680,673,393	$ 86,333,433	$ 19,898,669	$ -	$ -	**$ 1,786,905,495**
Managed Long-Term Services and Supports (MLTSS)	$ 597,571,457	$ -	$ 527,852	$ 395,487	$ -	**$ 598,494,795**
Prescription Drugs	$ -	$ 128,351,163	$ 8,875,230	$ -	$ -	**$ 137,226,393**
CalAIM & Other Medical	$ 135,707,207	$ 8,972,139	$ 3,519,679	$ -	$ -	**$ 148,199,026**
Medical Management	$ 132,698,285	$ 18,088,457	$ 19,056,585	$ 2,329,601	$ -	**$ 172,172,928**
Total	$ 3,884,377,197	$ 441,120,700	$ 51,878,014	$ 2,725,088	$ -	**$ 4,380,101,000**
MLR	***93.35%***	***94.32%***	***86.24%***	***91.18%***		***93.35%***
Gross Margin	$ 276,765,150	$ 26,578,707	$ 8,276,211	$ 263,560	$ -	**$ 311,883,628**
Administrative Expenses						
Salaries, Wages, & Employee Benefits	$ 148,352,599	$ 14,546,479	$ 2,229,017	$ 1,495,721	$ -	**$ 166,623,816**
Non-Salary Operating Expenses	$ 84,488,130	$ 9,427,166	$ 1,398,017	$ 120,250	$ 4,004,795	**$ 99,438,358**
Depreciation & Amortization	$ 11,372,543	$ -	$ 19,465	$ -	$ 2,299,716	**$ 13,691,724**
Indirect Cost Allocation, Occupancy Expense	$ (8,896,501)	$ 14,378,000	$ 209,920	$ 91,000	$ (6,304,511)	**$ (522,092)**
Total	$ 235,316,770	$ 38,351,645	$ 3,856,419	$ 1,706,971	$ -	**$ 279,231,806**
ALR	***5.66%***	***8.20%***	***6.41%***	***57.12%***		***5.95%***
Operating Income/(Loss) Ixcluding Provider Rate Increases	**$ 41,448,379**	**$ (11,772,938)**	**$ 4,419,793**	**$ (1,443,412)**	**$ -**	**$ 32,651,822**
						0.70%
Covered California						**$ (10,764,679)**
Digital Transformation Strategy						**$ (5,187,500)**
Non-Operating						
Net Investment Income						**$ 100,000,000**
500 Building						**$ (1,156,469)**
Street Medicine Support Center						**$ (506,847)**
Total Non-Operating Income/(Loss)						**$ 98,336,684**

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Attachment B: Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY 2025-26 Input	Authorization	Appropriation
Professional Fees	Financial Audit Annual Contract	230,000	X	X
Professional Fees	Cloud Platform Assistance, Work Station Management and Miscellaneous Consulting/Professional Services	227,000	X	X
Professional Fees	Support Campaign Development and Advertising Strategy	210,000	X	X
Professional Fees	Quality Assurance Support and Development	200,000	X	X
Professional Fees	Core Systems Upgrade Consultation, Technical Training and Other Core Application Support	197,000	X	X
Professional Fees	Support for Delegation Oversight Process	192,000	X	X
Professional Fees	Organizational and Strategic Plan Support	100,000	X	X
Professional Fees	Investment Advisory Support Services	100,000	X	X
Professional Fees	Consulting Services to Support Process Enhancement and Implementation	100,000	X	X
Professional Fees	Compensation and Job Classification Study	80,000	X	X
Professional Fees	Fraud Consultant to Assess CalOptima Health's Program Integrity Areas and Procedures.	80,000	X	X
Professional Fees	Third-Party Reviewers of Medical Records to Assess for Clinical Appropriateness and Coding/Billing Accuracy	70,000	X	X
Professional Fees	Accounting and Finance System Support	65,000	X	X
Professional Fees	Consulting Services for Budget Support	50,000	X	X
Professional Fees	Evaluation of End to End Workflow for System/Process Improvements	38,000	X	X
Purchased Services	Claims Prepayment Editing Services	3,300,000	X	X
Purchased Services	Face to Face Interpreter Services, Telephonic and Video Interpreter Services, Translation Services for Threshold Languages, Translation Audit Review and Translation Skill Assessment and Test	3,070,000	X	X
Purchased Services	Coordination Of Benefits (COB) Project	2,500,000	X	X
Purchased Services	Electronic Data Interchange Institutional Claims	1,688,000	X	X
Purchased Services	Overpayment Identification Services	1,500,000	X	X
Purchased Services	Third Party Check Printing and Mailing Fees	1,056,000	X	X
Purchased Services	Ongoing Digital, Social Media Advertising and Partnerships to Promote Routine Annual Medi-Cal Renewal, Mailing Campaign to Promote County Community Services Center	515,000	X	X
Purchased Services	Claims Imaging and Indexing Services	460,000	X	X
Purchased Services	Managed Services for Software Development and Quality Assurance Resources	440,000	X	X
Purchased Services	Supplemental Security Income (SSI) Conversion Services	420,000	X	X
Purchased Services	Business Bank Fees	385,000	X	X
Purchased Services	Managed Services for Data Masking, Printing Support and Customer Experience Platform	280,400	X	X
Purchased Services	Long Term Care Rate Adjustments	250,000	X	X
Purchased Services	Radio, Television, Print, Outdoor, Digital Advertising Campaign to Encourage Use of CalOptima-Covered Preventative Services	225,000	X	X
Purchased Services	Background Screening	225,000	X	X
Purchased Services	Business Workflow Platform Design and Support	204,000	X	X
Purchased Services	Health Insurance Portability and Accountability Act (HIPAA) Security Compliance, including Risk Management, Assessment and Network Penetration,	200,000	X	X
Purchased Services	Security Operations Center to Provide Expert Monitoring, Analysis, and Response to Security Incidents Using a Centralized Platform	150,000	X	X
Purchased Services	Data Modeling Pricing	150,000	X	X
Purchased Services	Fraud, Waste and Abuse (FWA) Recovery Fees	150,000	X	X

Attachment B: Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2025-26 Input**	**Authorization**	**Appropriation**
Purchased Services	Regulatory 508 Compliance Remediation Services for Pdf Files to Make Member, Provider, Board and Other Materials Accessible to People With Disabilities on the Website as Required by CMS, DHCS and Section 508 Regulations	130,000	X	X
Purchased Services	Insurance Broker Services	126,000	X	X
Purchased Services	Technical Development for Multiple Facet Projects	125,000	X	X
Purchased Services	Benefit Broker Services	123,000	X	X
Purchased Services	Data Scanning and Storage	120,000	X	X
Purchased Services	Moving Services and Armed Guards	105,000	X	X
Purchased Services	Provider Directory Production and Remediation, Other Miscellaneous Purchased Services	90,000	X	X
Purchased Services	Sponsorship of Television Network Featuring Brand Placement and Raising Awareness of Health Topics	70,000	X	X
Purchased Services	Recruitment Advertisement and Sourcing	65,000	X	X
Purchased Services	Employee Assistance Program	60,912	X	X
Purchased Services	Photography and Video Production Services to Support New CalOptima Initiatives	60,000	X	X
Purchased Services	Provider Office Diversity, Equity and Inclusion Training	60,000	X	X
Purchased Services	Offsite Backup Tape Storage and Services, Slotted Media Storage	54,100	X	X
Purchased Services	Flexible Spending Accounts (FSA)/Consolidated Omnibus Budget Reconciliation Act (COBRA)	50,000	X	X
Purchased Services	Retirement Funds Advisory	50,000	X	X
Purchased Services	Healthcare Productivity Automation Services	48,000	X	X
Purchased Services	Medical Records Retrieval, and Compliance and Ethics Hotline	35,000	X	X
Purchased Services	Compensation System Subscription Fee	34,200	X	X
Purchased Services	Grant Management Tools to Support Ongoing Management of Grants and Process Improvement	30,000	X	X
Purchased Services	TB Shots and Other General Purchased Services	30,000	X	X
Purchased Services	Pre Employment Applicant Testing	25,000	X	X
Purchased Services	Employee Wellness and Ad Hoc Programs	44,600	X	X
Purchased Services	Centralized Procurement Platform Support	17,000	X	X
Purchased Services	Health Screening	15,000	X	X
Purchased Services	Destruction of Electronic Media	10,500	X	X
Purchased Services	Tax Form Processing Fees and Other General Purchased Services	6,000	X	X
Purchased Services	Imaging Services	4,000	X	X
	Total Non-Salary Operating Expenses	**84,488,130**		

Attachment B: Administrative Budget Details

	OneCare: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2025-26 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Claims Pricing Solution	761,400	X	X
Other Operating Expenses	Activities and Promotional Items for Community Events	305,000	X	X
Other Operating Expenses	Predictive Analytics Modeling and Decision Point	220,000	X	X
Other Operating Expenses	Food Services Allowances, as Needed, for Sponsoring Member and Provider Meetings, Conferences, Community Events, Compliance Week, and Department Training and Meeting	103,500	X	X
Other Operating Expenses	Activities and Promotional Items for Various Events	50,000	X	X
Other Operating Expenses	Travel Expenses for Visits to Provider Offices, Presentations, Health Fairs, Community Events, Annual Audits and Conferences/Seminars	28,800	X	X
Other Operating Expenses	Subscriptions, Certifications, Licenses and Professional Dues	16,650	X	X
Other Operating Expenses	Training and Seminars for Professional Development and Education	14,000	X	X
Other Operating Expenses	Office Supplies	8,700	X	X
Other Operating Expenses	Minor Equipment Supplies	5,000	X	X
Printing & Postage	Marketing Materials, Including Sales Brochures, Posters, Handouts and Other Member and Provider Oriented Materials and Postage	676,000	X	X
Printing & Postage	Maintenance of Enrolled Members (Printing, Fulfillment, Postage), Member Routine Annual and Quarterly Mailings, Other Related Printing and Postage Expenses	615,336	X	X
Printing & Postage	Printing of Enrollment Materials, Retainment Materials, Broker Agency Enrollment Kits, and Other Related Printing Expenses	98,000	X	X
Printing & Postage	Member and Provider Materials, Fulfillment and Other Printing Fees for Various Departments	58,750	X	X
Printing & Postage	Delivery and Mailing	5,200	X	X
Professional Fees	Medicare Consultants and Agency Services	674,000	X	X
Professional Fees	Annual Contract Bid for Other Financial Consulting Services	440,000	X	X
Professional Fees	Medicare Data Validation Audit and Program Audit Engagement	235,000	X	X
Professional Fees	Annual Compliance Program Effectiveness (CPE) Audit	60,000	X	X
Professional Fees	External Medical Review	3,600	X	X
Purchased Services	Advertising and Media Buys (Newspapers, Magazines, Radio, Bus Shelter, Campaigns, Other Media)	1,385,000	X	X
Purchased Services	Pharmacy Benefits Management	1,214,130	X	X
Purchased Services	Broker Agency Commission for Member Enrollment and Other Related Expenses	1,010,000	X	X
Purchased Services	Language Interpretation, Face to Face Interpreter Services, Telephonic Interpreter and Video Interpreting Services, and Translation of Member Materials	551,600	X	X
Purchased Services	Community-Based Health Organization to Deliver Care Programs	300,000	X	X
Purchased Services	Member Chart Retrieval Services	202,500	X	X
Purchased Services	Managed Service Support for Member and Provider Engagement	120,000	X	X
Purchased Services	Risk Management, Data Security, and Process Automation Services	120,000	X	X
Purchased Services	Provider Directory Production for Regulatory 508 Compliance	90,000	X	X
Purchased Services	Claims Processing Through Automation Data Flow	30,000	X	X
Purchased Services	Data Scanning and Storage	25,000	X	X
	Total Non-Salary Operating Expenses	**9,427,166**		

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Attachment B: Administrative Budget Details

	PACE: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2025-26 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Repairs and Maintenance of Minor Equipment, Building and Unforeseen Incidentals and Support for Encounters	83,311	X	X
Other Operating Expenses	Outreach Events and Promotional Marketing Items to Help Elevate PACE Center and Support Program Enrollment and Expansion	22,400	X	X
Other Operating Expenses	Electricity, Gas, Water and Other Related Expenses	8,000	X	X
Other Operating Expenses	General Liability, Property, Earthquake and Other Insurance Fees	7,247	X	X
Other Operating Expenses	Enrollment Incentive Program	4,400	X	X
Other Operating Expenses	Food Services Allowances, as Needed, for Sponsoring, Enrollment and Retention Events, Member and Provider Meetings, Conferences and Trainings	4,264	X	X
Other Operating Expenses	Property Tax Assessment	2,000	X	X
Other Operating Expenses	Staff Development Training (Registration Fees, Travel, Accommodations, Incidentals)	1,440	X	X
Other Operating Expenses	Office Supplies for Staff	960	X	X
Other Operating Expenses	Staff Travel and Mileage for Home Visits, Marketing, Conferences and Enrollment	960	X	X
Other Operating Expenses	Subscriptions, Membership, Registration for Dietetic and Other Discipline Specific Memberships	456	X	X
Other Operating Expenses	Minor Equipment and Supplies (Kitchen, Rehab, Social Day, Staff Break Room, Clinic/Rehab Equipment)	400	X	X
Printing & Postage	Participant Newsletter, Typesetting for Translated Materials, Printing, Fulfillment and Postage Costs for Direct Mail Campaign, Marketing Materials and Other Printing Expenses	261,440	X	X
Professional Fees	Part D Actuarial Services and Other Financial Consulting Fees	164,800	X	X
Purchased Services	Advertising (Radio, Television, Print, Outdoor, Digital and Other Mediums) to Promote and Support Enrollment and Participation	825,000	X	X
Purchased Services	Health Outcomes and Satisfaction Surveys, Encounter Data File Formatting, Sterilization of Medical Equipment, Provider Communication, Appointment Services, Telehealth Support Services, Medical Equipment Calibration and Other Related Expenses	10,939	X	X
	Total Non-Salary Operating Expenses	**1,398,017**		

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Attachment B: Administrative Budget Details

	MSSP: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2025-26 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Information Management Software for Long Term Care	50,000	X	X
Other Operating Expenses	Regular Home Visits with Members for Field Staff and Quarterly Director Site Meeting	19,000	X	X
Other Operating Expenses	Cell Phones and Data Plans for Field Staff and Management Team Who Complete Onsite Home Assessments	19,000	X	X
Other Operating Expenses	Professional Certifications	11,500	X	X
Other Operating Expenses	Professional Development and Education	2,500	X	X
Other Operating Expenses	Routine Office Supplies for Field and Office Staff	250	X	X
Professional Fees	Annual Finance Audit	18,000	X	X
	Total Non-Salary Operating Expenses	**120,250**		

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Attachment B: Administrative Budget Details

	505 Building: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2025-26 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Building Repair and Maintenance	2,637,702	X	X
Other Operating Expenses	Utilities	686,682	X	X
Other Operating Expenses	Property Insurance	301,484	X	X
Other Operating Expenses	Property Tax Assessments	22,428	X	X
Purchased Services	Building Support Services	216,499	X	X
Purchased Services	Property Management Fee	140,000	X	X
	Total Non-Salary Operating Expenses	**4,004,795**		

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Attachment B: Administrative Budget Details

	500 Building: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2025-26 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Building Repair and Maintenance	1,255,889	X	X
Other Operating Expenses	Utilities	367,468	X	X
Other Operating Expenses	Property Insurance	110,934	X	X
Other Operating Expenses	Property Tax Assessments	8,108	X	X
Purchased Services	Property Management Fee	140,000	X	X
Purchased Services	Building Support Services	89,570	X	X
	Total Non-Salary Operating Expenses	**1,971,969**		

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Attachment B1: Covered California

	Covered California: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2025-26 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Software Licenses Pertaining to Capital Projects	500,000	X	X
Other Operating Expenses	Training and Seminars for Professional Development	15,750	X	X
Other Operating Expenses	General Office Supplies	2,500	X	X
Other Operating Expenses	Food Services	400	X	X
Printing & Postage	Certified Postage and Overnight and Special Courier Mail	250	X	X
Professional Fees	Strategic Advice and Qualified Health Plan (QHP) Application Support and Operational Implementation Support and Project Management	2,120,000	X	X
Professional Fees	Campaign Development for Launch of Covered California Plan	1,500,000	X	X
Professional Fees	General and Adversarial Legal Fees for Outside Legal Counsel	750,000	X	X
Professional Fees	Actuarial Support for Financial Projections and Rate Development	550,000	X	X
Professional Fees	Support for Implementation of Receivables and Billing Systems	100,000	X	X
Purchased Services	Member Premiums System	250,000	X	X
Purchased Services	Quality Assurance Service for Compliance and Implementation	240,000	X	X
Purchased Services	Translation and Printing Services	134,000	X	X
	Total Non-Salary Operating Expenses	**6,162,900**		

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Attachment B2: Digital Transformation

	Digital Transformation: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2025-26 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Software Licenses Pertaining to Capital Projects	2,187,500	X	X
Professional Fees	Digital Transformation Consulting Services in Various Areas	3,000,000	X	X
	Total Non-Salary Operating Expenses	**5,187,500**		

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

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

Contact

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

Recommended Actions

1. Approve the CalOptima Health Fiscal Year 2025-26 Routine Capital Budget and authorize expenditures and appropriate funds for the items in Attachment A: Fiscal Year 2025-26 Routine Capital Budget by Project.
2. Approve the CalOptima Health Fiscal Year 2025-26 Covered California Capital Budget, allocate up to $3.72 million from existing reserves to fund pre-implementation expenditures related to Covered California, and authorize expenditures and appropriate funds for the items in Attachment A1: Fiscal Year 2025-26 Covered California Capital Budget by Project.
3. Approve the CalOptima Health Fiscal Year 2025-26 Digital Transformation Year Four Capital Budget, extend the Digital Transformation Strategy for two years, through June 30, 2027, to complete ongoing and new projects, and authorize expenditures and appropriate funds for the items in Attachment A2: Update to Digital Transformation Years One through Three and Year Four Capital Budgets by Project.

Background

As of March 31, 2025, CalOptima Health recorded gross capital assets of $194.4 million in the 505 Building, 500 Building, Street Medicine Support Center in Garden Grove, building improvements, furniture, equipment, subscription assets, and information systems, including Digital Transformation projects. To account for these fixed assets wearing out over time, staff has charged against the costs of these assets an accumulated depreciation and amortization totaling $94.1 million. Staff will record capital assets acquired in Fiscal Year (FY) 2025-26 at acquisition cost and will depreciate the value on a straight-line basis over their estimated useful lives as follows:

- Five (5) years for office furniture and fixtures;
- Three (3) years for computer equipment and software;
- The lesser of fifteen (15) years or remaining term of lease for leasehold improvements; and
- Ten (10) to twenty (20) years, based on components, for building improvements.

The resulting net book value of these fixed assets was $100.3 million as of March 31, 2025. Prior Board of Directors (Board)-approved Routine Capital budgets were $8.26 million in FY 2024-25 and $14.7 million in FY 2023-24.

Pursuant to CalOptima Health Policies GA.3202: CalOptima Health Signature Authority, GA.5002: Purchasing, and GA.5003: Budget Approval and Budget Reallocation, the Board's approval of the budget authorizes the expenditure for the item and appropriates the funds requested without further

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Board action to the extent the Board has or is, as indicated in the budget attachments, delegating authority to staff.

Discussion

A. FY 2025-26 Routine Capital Budget

Staff proposes a Routine Capital Budget of $28.5 million for FY 2025-26 in the areas of Information Technology (IT) and Building and Office Improvements. More detailed information is provided in Attachment A: Fiscal Year 2025-26 Routine Capital Budget by Project.

Capital Budget Area	FY 2025-26 Budget	% of Total
1. Information Technology	$17,333,500	60.7%
2. Building and Office Improvements	$11,202,500	39.3%
Total:	$28,536,000	100.0%*

* Totals may not add up due to rounding.

FY 2025-26 Routine Capital Budget by Area

1. Information Technology: IT represents $17.3 million or 60.7% of the Routine Capital Budget. This category includes funding for hardware, professional fees, and information technology labor resources related to the implementation of capital projects. These upgrades are necessary to support internal operations and to ensure compliance with state and federal requirements.

Capital Budget Category	FY 2025-26 Budget	% of Total
Infrastructure	$9,047,500	52.2%
Applications Management	$3,981,000	23.0%
Enterprise Data and System Integration	$950,000	5.5%
Application Development	$3,355,000	19.4%
Total:	**$**17,333,500	100.0%*

* Totals may not add up due to rounding.

2. Building and Office Improvements: Building and Office Improvements represent $11.2 million or 39.3% of the Routine Capital Budget. This category includes the 505 Building, 500 Building, PACE Center, and Street Medicine Support Center. Please refer to the attached Summary of CalOptima Health Facilities for more information.

Capital Budget Category	FY 2025-26 Budget	% of Total
505 Building Improvements	$4,780,000	42.7%
500 Building Improvements	$4,830,000	43.1%
PACE Center	$1,342,500	12.0%
Street Medicine Support Center	$250,000	2.2%
Total:	$11,202,500	100.0%*

* Totals may not add up due to rounding.

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B. FY 2025-26 Covered California Capital Budget

At the January 14, 2025, meeting, the Orange County Board of Supervisors approved a change to CalOptima Health's county ordinance to remove the provisions prohibiting participation in Covered California. The target start date for CalOptima Health's participation in Covered California is January 1, 2027. The Covered California Capital Budget includes projects that have been initially identified as necessary to build the internal capacity and infrastructure for the new line of business. More detailed information is provided in Attachment A1: Fiscal Year 2025-26 Covered California Capital Budget by Project.

Capital Budget Category	FY 2025-26 Budget	% of Total
Applications Management	$885,000	23.8%
Enterprise Data and System Integration	$1,350,000	36.3%
Application Development	$1,480,520	39.8%
Total:	$3,715,520	100.0%*

* Totals may not add up due to rounding.

C. Update to Digital Transformation Capital Budgets

On March 17, 2022, the Board authorized a three-year Digital Transformation and Workplace Modernization Strategy (beginning July 1, 2022, through June 30, 2025) and created a $100 million restricted reserve to fund digital transformation efforts. Since then, staff has worked quickly to develop and implement key components of the strategy. The Board approved the Digital Transformation Year One, Year Two, and Year Three Capital Budgets on June 2, 2022, June 1, 2023, and June 6, 2024, respectively. Through separate Board actions, the Board also updated and revised certain capital projects and funding levels within these budgets.

Staff recommends Board approval of the following:

- Update to Digital Transformation Years One through Three Capital Budgets: As CalOptima Health nears the end of the initial three-year strategy, staff has evaluated the status and updated the funding levels, where necessary, for each remaining project that received Board approval in previous capital budgets.
- Two-year extension of the Digital Transformation Strategy: Due to the longer timeframes to implement capital projects, staff requests a two-year extension of the Digital Transformation Strategy through June 30, 2027, to complete existing projects in process and the proposed new capital projects for year four.

- Approval of new capital projects for FY 2025-26: The Digital Transformation Year Four Capital Budget totals $11.95 million. The proposed capital projects will be funded from the remaining available resources in the restricted reserve.

The updated budget totals $32.1 million and includes a consolidated list of Year One through Three existing capital projects that will continue in FY 2025-26, and new capital projects in Year Four. After Board approval, staff will revise the amount of capital assets based on the updated list of capital projects.

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After accounting for actual and budgeted capital and operating costs for years one through four, staff estimates there will be approximately $0.3 million remaining in the $100 million restricted reserve. For more detailed information, please refer to Attachment A2: Update to the Digital Transformation Years One through Three and Year Four Capital Budgets by Project.

Fiscal Impact

Routine Capital Budget: The fiscal impact for the Routine Capital Budget is $28,536,000 and will be funded by CalOptima Health's net assets.

Covered California: The fiscal impact for the Covered California Capital Budget is $3,715,520. An allocation of up to $3.72 million from existing reserves will fund the budget.

Digital Transformation: A previous Board action on March 17, 2022, created a $100 million restricted reserve to fund digital transformation efforts. The remaining funds in the restricted reserve are sufficient to cover the Digital Transformation Year Four capital projects, with no new funding requested.

Depreciation expenses for Capital Budget projects are reflected in the proposed FY 2025-26 CalOptima Health Operating Budget.

Rationale for Recommendation

The FY 2025-26 Routine Capital, Covered California, and Digital Transformation Year Four Capital Budgets will enable necessary office improvements, system upgrades, enhance operational efficiencies to support CalOptima Health's Mission and Vision statements and Strategic Plan, and comply with federal and state requirements.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt
Board of Directors' Finance and Audit Committee

Attachments

1. Attachment A: Fiscal Year 2025-26 Routine Capital Budget by Project
2. Attachment A1: Fiscal Year 2025-26 Covered California Capital Budget by Project
3. Attachment A2: Update to Digital Transformation Years One through Three and Year Four Capital Budgets by Project
4. Summary of CalOptima Health Facilities
5. Fiscal Year 2025-26 Capital Budgets Presentation

/s/ Michael Hunn *05/30/2025*
Authorized Signature **Date**

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Attachment A: Fiscal Year 2025-26 Routine Capital Budget by Project

INFRASTRUCTURE	TOTAL CAPITAL
Hardware and Software Network Firewall Upgrades	1,905,000
Disaster Recovery System Upgrades and Protection Points	1,765,000
Employee Computer and Server Operating System Upgrades	1,644,500
Enterprise Data Masking to Protect Health Information	1,255,000
Cyber Security and Vulnerability System Remediation	1,195,000
Service Desk and Workforce Workflow Enhancements	733,000
On-Premise to Cloud Infrastructure Migrations	300,000
Member Contract Outbound Caller Identification	150,000
Physical and Electronic Security Controls Upgrade at the Orange County CalOptima Health Data Center	100,000
TOTAL INFRASTRUCTURE	**$ 9,047,500**

APPLICATIONS MANAGEMENT	TOTAL CAPITAL
Enterprise Print and Fulfillment Solution - Operations, Clinical, and Payment Solution	1,750,000
Enterprise Claims and Encounters Data Management Solution	900,000
Core Operational Application Software Upgrades	703,000
Clinical Operational Application Software Upgrades	628,000
TOTAL APPLICATIONS MANAGEMENT	**$ 3,981,000**

ENTERPRISE DATA AND SYSTEMS INTEGRATION	TOTAL CAPITAL
Regulatory Reporting and Compliance Enhancements	500,000
Data Integration Upgrades for Quality Stars and HEDIS Measurements	450,000
TOTAL ENTERPRISE DATA AND SYSTEMS INTEGRATION	**$ 950,000**

APPLICATIONS DEVELOPMENT	TOTAL CAPITAL
CalOptima Health Public Website Enhancements (Phase II)	1,125,000
Member and Provider Portal Workflow and Privacy Enhancements	1,030,000
Automated Application for the Board and Committee Material Preparation	625,000
Corporate Legacy Workflow Applications Replacement for Enterprise Workflow Product	375,000
Portal Online User Identity Management Upgrade	200,000
TOTAL APPLICATIONS DEVELOPMENT	**$ 3,355,000**

505 BUILDING IMPROVEMENTS	TOTAL CAPITAL
Lighting Retrofit	1,200,000
Tenant Improvements	950,000
Building Window Film	900,000
Carpet Replacement	675,000
Office Furniture	450,000
Fire Panel Upgrade	150,000
Security Camera Upgrades	100,000
Rooftop Signage Structural Upgrade	100,000
1st Floor Elevator Fire Curtains	80,000
Air Conditioning System for Computer Room	70,000
Chiller Equipment Refurbishment	70,000
Cooling Tower Refurbishment	35,000
TOTAL 505 BUILDING IMPROVEMENTS	**$ 4,780,000**

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Attachment A: Fiscal Year 2025-26 Routine Capital Budget by Project

500 BUILDING IMPROVEMENTS	TOTAL CAPITAL
Tenant Improvements Suites 100, 110, 120	3,595,000
Lighting Retrofit	250,000
Accessibility Code Upgrades for Path of Travel	200,000
Security Desk and Camera System Upgrades	200,000
Parking Lot Restripe	175,000
Fire Alarm System Upgrades	165,000
Rooftop Signage Structural Upgrade	100,000
Tenant Improvements Suite 250	75,000
Air Conditioning System for Computer Room	70,000
TOTAL 500 BUILDING IMPROVEMENTS	**$ 4,830,000**

PACE CENTER	TOTAL CAPITAL
Electronic Health Record (EHR) System	872,500
Lighting Retrofit	150,000
Exterior Building Signage Update	125,000
Rooftop Air Conditioning Unit Replacement	60,000
Equipment Upgrades and Replacement	50,000
Exterior Landscape Upgrade	30,000
Wander Guard System	30,000
Security Camera Upgrades	25,000
TOTAL PACE CENTER	**$ 1,342,500**

STREET MEDICINE SUPPORT CENTER	TOTAL CAPITAL
Street Medicine Support Center Redevelopment	250,000
STREET MEDICINE SUPPORT CENTER	**$ 250,000**

TOTAL FY 2025-26 ROUTINE CAPITAL BUDGET	**$ 28,536,000**

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Attachment A1: Fiscal Year 2025-26 Covered California Capital Budget by Project

APPLICATIONS MANAGEMENT	TOTAL CAPITAL
Core System Configuration	885,000
TOTAL APPLICATIONS MANAGEMENT	**$ 885,000**

ENTERPRISE DATA AND SYSTEMS INTEGRATION	TOTAL CAPITAL
Regulatory Enrollment Transactions and Reporting	825,000
Regulatory Operational Reconciliation Reporting	525,000
TOTAL ENTERPRISE DATA AND SYSTEMS INTEGRATION	**$ 1,350,000**

APPLICATIONS DEVELOPMENT	TOTAL CAPITAL
Online Billing and Collection Platform for Member Premiums	755,520
Online Broker Sales Platform and Website Enhancements	725,000
TOTAL APPLICATIONS DEVELOPMENT	**$ 1,480,520**

TOTAL FY 2025-26 COVERED CALIFORNIA CAPITAL BUDGET	**$ 3,715,520**

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Attachment A2: Update to Digital Transformation Years One through Three and Year Four Capital Budgets by Project

	Updated			Proposed	
INFRASTRUCTURE	**FY 2022-2023 (Year 1)**	**FY 2023-2024 (Year 2)**	**FY 2024-2025 (Year 3)**	**FY 2025-2026 (Year 4)**	**TOTAL CAPITAL**
On-Premise Fax Server Replacement to a Supported Digital Cloud Fax Solution	75,000	75,000	-	50,000	200,000
TOTAL INFRASTRUCTURE	**$ 75,000**	**$ 75,000**	**$ -**	**$ 50,000**	**$ 200,000**

APPLICATIONS MANAGEMENT	**FY 2022-2023 (Year 1)**	**FY 2023-2024 (Year 2)**	**FY 2024-2025 (Year 3)**	**FY 2025-2026 (Year 4)**	**TOTAL CAPITAL**
Provider Credential and Contracting Implementation to Enhance Workflow and Reduce Transactional Backlogs	1,636,000	1,964,000	-	3,875,000	7,475,000
Customer Relationship Management Platform Development to Automate Member and Provider Call Center Experience	231,250	2,000,000	-	2,790,000	5,021,250
Clinical Care Management Platform for Member Care Assessments and Engagement with Providers	1,851,000	500,000	249,000	-	2,600,000
Enterprise Finance System	556,000	-	1,150,000	-	1,706,000
Robotic Automation Processes Development and Implementation for Operational Processes in Member and Provider Systems	1,500,000	-	-	200,000	1,700,000
Digitize Authorization Faxes into the Clinical Platform Workflow for Automated Treatment Authorization with Providers	-	-	-	1,275,000	1,275,000
TOTAL APPLICATIONS MANAGEMENT	**$ 5,774,250**	**$ 4,464,000**	**$ 1,399,000**	**$ 8,140,000**	**$ 19,777,250**

ENTERPRISE DATA AND SYSTEMS INTEGRATION	**FY 2022-2023 (Year 1)**	**FY 2023-2024 (Year 2)**	**FY 2024-2025 (Year 3)**	**FY 2025-2026 (Year 4)**	**TOTAL CAPITAL**
Enhancement of Data Warehouse Ecosystem to Enterprise Level Data Strategy and Management	275,000	-	2,700,000	415,000	3,390,000
Health Information Data Exchange for Provider Access and Member Care	-	-	-	1,020,000	1,020,000
Enterprise Application Data Exchange Platform Enhancement	-	-	-	755,000	755,000
Retire the End of Life Reporting Platform and Migrate to the Cloud Reporting Application	25,500	300,000	-	135,000	460,500
TOTAL ENTERPRISE DATA AND SYSTEMS INTEGRATION	**$ 300,500**	**$ 300,000**	**$ 2,700,000**	**$ 2,325,000**	**$ 5,625,500**

APPLICATIONS DEVELOPMENT	**FY 2022-2023 (Year 1)**	**FY 2023-2024 (Year 2)**	**FY 2024-2025 (Year 3)**	**FY 2025-2026 (Year 4)**	**TOTAL CAPITAL**
New Member Experience Application	-	-	2,000,000	1,325,000	3,325,000
Website Content Management Controls Migration to the Cloud	750,000	1,567,100	70,000	85,000	2,472,100
Human Capital Management System	-	350,000	100,000	-	450,000
TOTAL APPLICATIONS DEVELOPMENT	**$ 750,000**	**$ 1,917,100**	**$ 2,170,000**	**$ 1,410,000**	**$ 6,247,100**

CYBER SECURITY	**FY 2022-2023 (Year 1)**	**FY 2023-2024 (Year 2)**	**FY 2024-2025 (Year 3)**	**FY 2025-2026 (Year 4)**	**TOTAL CAPITAL**
Secure File Encryption Platform Upgrade	-	-	200,000	25,000	225,000
TOTAL CYBER SECURITY	**$ -**	**$ -**	**$ 200,000**	**$ 25,000**	**$ 225,000**

TOTAL UPDATE TO DIGITAL TRANSFORMATION YEARS ONE THROUGH THREE AND YEAR FOUR CAPITAL BUDGET	**$ 6,899,750**	**$ 6,756,100**	**$ 6,469,000**	**$ 11,950,000**	**$ 32,074,850**

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Summary of CalOptima Health Facilities

CalOptima Health operations are conducted at various locations in Orange County to support the Medi-Cal, OneCare, and PACE lines of business. The summary below provides some background information on these facilities.

505 Building: This property is located at 505 City Parkway West, Orange, California. On January 6, 2011, the CalOptima Health Board of Directors (Board) approved the purchase of the property, which became the headquarters on March 5, 2012.

500 Building: This property is located at 500 City Parkway West, Orange, California. On March 17, 2022, the Board approved the purchase of the property. The property will house, among other things, CalOptima Health's member services and the Care Traffic Control Command Center in Orange County.

PACE Center: This property is located at 13300 Garden Grove Boulevard, Garden Grove, California. On February 3, 2011, the Board authorized a lease for the property to serve as the location for the PACE Center. At the June 3, 2021, meeting, the Board extended the lease agreement for ten additional years, through December 31, 2031.

Street Medicine Support Center: This property is located at 7900 Garden Grove Boulevard, Garden Grove, California. On October 5, 2023, the Board approved the purchase of the property, which is the location for the Street Medicine Support Center. The center is tentatively scheduled to open in Spring 2025.

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CalOptima Health

Fiscal Year 2025-26 Capital Budgets

Board of Directors Meeting

June 5, 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.

Agenda

- FY 2025-26 Routine Capital Budget
  - Information Technology
  - Building and Office Improvements
- FY 2025-26 Covered California Capital Budget
- Digital Transformation Strategy (DTS)
  - Update to Digital Transformation Years One through Three and Year Four Capital Budgets
  - DTS Resource Allocation Summary
- Recommended Actions

FY 2025-26 Budget (Capital Budget Funded)
ROUTINE CAPITAL

$28,536,000

FY 2025-26 Budget (Reserve Funded)
COVERED CALIFORNIA CAPITAL

$3,715,520

FY 2025-26 Budget
TOTAL CAPITAL

$32,251,520

FY 2025-26
Routine Capital Budget

FY 2025-26 Routine Capital Budget

Capital Budget Area	FY 2025-26 Budget	% of Total
Information Technology (IT) related capital projects	$17,333,500	60.7%
Building and Office Improvements (505 Building, 500 Building, PACE Center, Street Medicine Support Center)	$11,202,500	39.3%
Total:	**$28,536,000**	**100.0%**

- Departments submit requests for capital projects based on strategic and operational needs
- IT Department reviews technology requests

Information Technology

Capital Budget Category	FY 2025-26 Budget
Infrastructure (e.g., Hardware and Software Network Firewall Upgrades)	$9,047,500
Applications Management (e.g., Automation of Member and Provider Letter Print and Fulfillment)	$3,981,000
Enterprise Data and System Integration (e.g., Regulatory Reporting and Compliance Enhancements)	$950,000
Application Development (e.g., CalOptima Health Public Website Enhancements)	$3,355,000
Total:	**$17,333,500**

- Represents about 60.7% of the Routine Capital Budget
- Addresses information technology infrastructure needs to support current internal operations
- Ensures compliance with state and federal requirements

Note: Capital project details can be found in Attachment A: Fiscal Year 2025-26 Routine Capital Budget by Project

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Building and Office Improvements

Capital Budget Category	FY 2025-26 Budget
505 Building Improvements	$4,780,000
500 Building Improvements	$4,830,000
PACE Center	$1,342,500
Street Medicine Support Center	$250,000
Total:	**$11,202,500**

- Represents nearly 39.3% of the Routine Capital Budget

Note: Capital project details can be found in Attachment A: Fiscal Year 2025-26 Routine Capital Budget by Project

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CalOptima Health

BOARD

Covered California

FY 2025-26 Covered California Capital Budget

Capital Budget Category	FY 2025-26 Budget
Applications Management (e.g., Core System Configuration)	$885,000
Enterprise Data and Systems Integration (e.g., Regulatory Enrollment Transactions and Reporting)	$1,350,000
Application Development (e.g., Online Billing and Collection Platform for Member Premiums)	$1,480,520
Total:	**$3,715,520**

- Budget reflects capital projects that have been initially identified as necessary to build the internal capacity and infrastructure
- Staff will request additional funding, if needed, through separate Board actions

Note: Capital project details can be found in Attachment A1: Fiscal Year 2025-26 Covered California Capital Budget by Project

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CalOptima Health

BOARD

Covered California Budget Summary

	FY 2025-26 (Year 1)
Capital Budget	$3,715,520
Operating Budget	$10,764,679
Total:	**$14,480,199**

- 12/5/24: Board created a restricted Covered California Start-up Reserve Fund of $4.75 million from existing reserves to fund Covered California start-up costs through 12/31/26

Digital Transformation Strategy

Update to Digital Transformation Years One through Three and Year Four Capital Budgets

	FY 2022-23 (Year 1)	FY 2023-24 (Year 2)	FY 2024-25 (Year 3)	FY 2025-26 (Year 4)	Total Budget
Capital Projects by Category	**$6,899,750**	**$6,756,100**	**$6,469,000**	**$11,950,000**	**$32,074,850**
Infrastructure	$75,000	$75,000	--	$50,000	$200,000
Applications Management	$5,774,250	$4,464,000	$1,399,000	$8,140,000	$19,777,250
Enterprise Data and Systems Integration	$300,500	$300,000	$2,700,000	$2,325,000	$5,625,500
Applications Development	$750,000	$1,917,100	$2,170,000	$1,410,000	$6,247,100
Cyber Security	--	--	$200,000	$25,000	$225,000

Notes:

- 3/17/22: Board authorized a three-year strategy and created a $100 million restricted reserve to fund digital transformation efforts
- Capital project details can be found in Attachment A2: Update to the Digital Transformation Years One through Three and Year Four Capital Budgets by Project
- Totals may not add due to rounding

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BOARD

DTS Resource Allocation Summary

	FY 2022-23 (Year 1)	FY 2023-24 (Year 2)	FY 2024-25 (Year 3)	FY 2025-26 (Year 4)	FY 2026-27 (Year 5)	Total
Capital						
Budget	$6,899,750	$6,756,100	$6,469,000	$11,950,000	$308,394	$32,383,244
Completed Projects	$1,530,430	$3,468,281	$1,761,442	--	--	$6,760,153
Operating						
Actuals/ Budget	$8,381,011	$22,788,092	$24,500,000	$5,187,500	--	$60,856,603
Grand Total:	**$16,811,191**	**$33,012,473**	**$32,730,442**	**$17,137,500**	**$308,394**	**$100,000,000**
				Total Funding:		**$100,000,000**

* Totals may not add up due to rounding

Notes:
Capital: Amounts are from the Update to the Digital Transformation Capital Budgets

Operating: Years One and Two amounts reflect actual expenditures; Year Three amount is the projected expenditures based on actuals as of 3/31/25

Digital Transformation Strategy

Achieve CalOptima Health's mission and strategic vision through digital transformation

Member Experience	Seamless access to care, personalized support and communication to ensure members both are, and feel, cared for
Provider Experience	Streamlined processes to enhance the delivery of quality care, enabling same day treatment authorizations and real time claims payments
Employee Experience	Employees are equipped with the tools to succeed in delivering on the commitment to improved member and provider experience
Infrastructure & Governance	Secure, resilient and flexible infrastructure to support transformation, and alignment between the business, technology, and finance for ongoing transformation

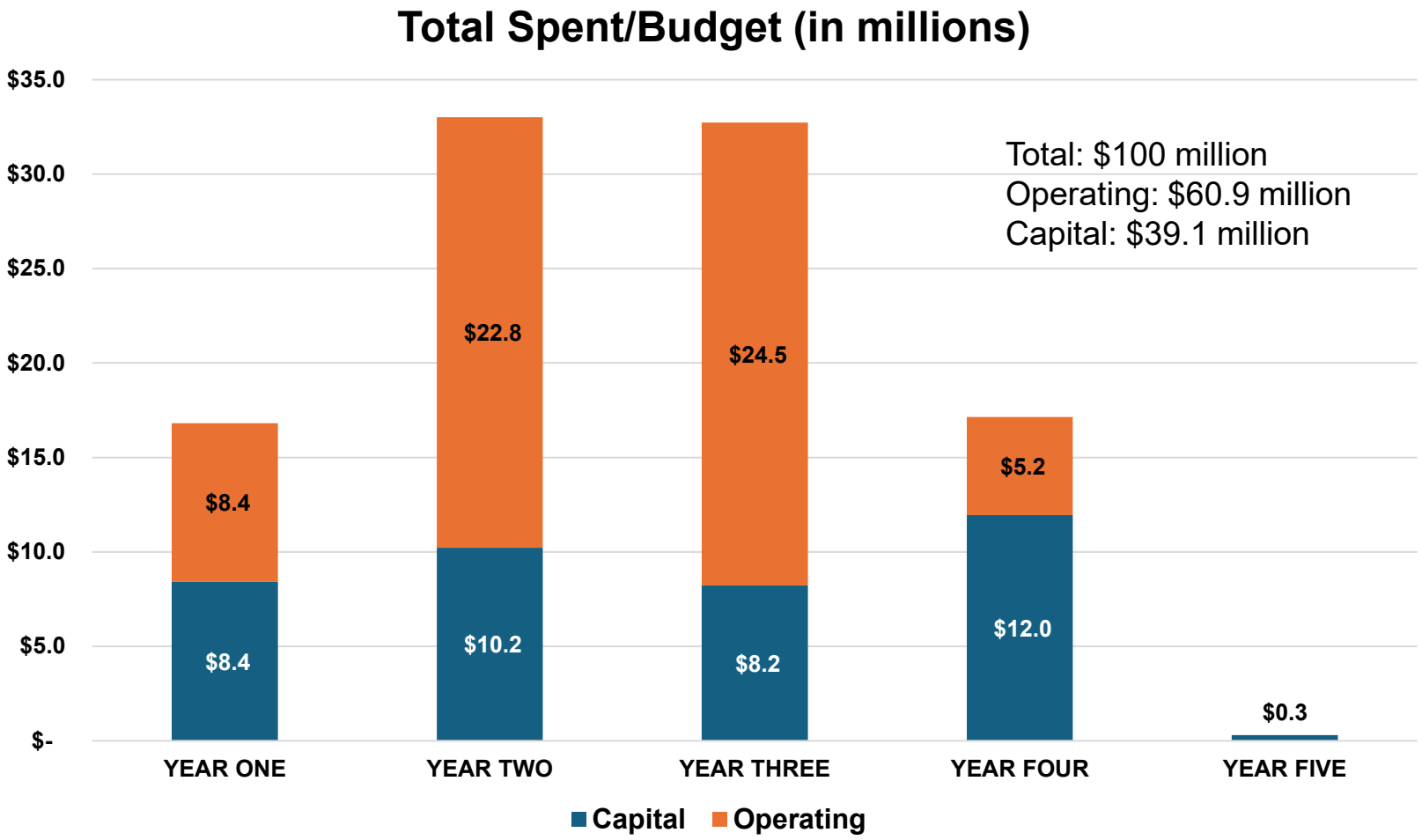
Digital Transformation Strategy
Deliverables

	YEAR 1 DELIVERED	YEAR 2 DELIVERED	YEAR 3 DELIVERED
Member Experience	✓ Implemented call center call-back system ✓ Enhanced member portal	✓ Utilized predictive analytics for text outreach to guide members through their care ✓ Implemented social determinants data collection	✓ Implemented new contact center telephony system ✓ Modernized CalOptima.org website
Provider Experience	✓ Enhanced CalAIM referral system ✓ Enhanced provider portal	✓ Replaced care management and utilization management system ✓ Launched robotics process automation (RPA) for claims automation	✓ Continued RPA enhancements for Operations ✓ Implemented reports from the new care management system ✓ Integrated care management system with online member health education material
Employee Experience	✓ Implemented Wi-Fi network and device mobility ✓ Implemented encounter processing system	✓ Replaced IT service management system ✓ Implemented fraud/waste/abuse detection system ✓ Upgraded phone system ✓ Replaced recruitment and onboarding system ✓ Expanded remote access	✓ Replaced the legacy reporting system to a new contemporary, cloud reporting platform
Infrastructure & Governance	✓ Enhanced IT staffing ✓ Implemented cybersecurity program ✓ Migrated in-house application to the cloud ✓ Launched cloud migration	✓ Delivered full system architecture ✓ Implemented data protection/recovery system ✓ Created information security governance model and playbook ✓ Deployed Zero Trust Network Architecture ✓ Established 24/7 security monitoring	✓ Implemented a Business Continuity System ✓ Eliminated VPN risk

Digital Transformation Strategy
Deliverables

	YEAR 4 + 5 IN-FLIGHT/PLANNED
Member Experience	• Implement Customer Relationship Management Platform with AI Next Best Action for Members • Deliver improved member experience and Health Journey App
Provider Experience	• Implement Provider Credentialing and Contract Management System • Enable provider self-service for treatment authorizations • Enhance Provider Data Management • Implement improved Health Information Data Exchange for Provider Access and Member Care
Employee Experience	• Implement a new Enterprise Finance system • Implement a new HR Management System
Infrastructure & Governance	• Enhance the Data Warehouse Ecosystem to Enterprise Level Data Strategy and Management • Mask PHI/PII in non-production environments • Implement centralized network monitoring system (NOC)

Digital Transformation Strategy
Budget



Recommended Actions

- Approve the CalOptima Health Fiscal Year 2025-26 Routine Capital Budget, and authorize expenditures and appropriate funds for the items in Attachment A: Fiscal Year 2025-26 Routine Capital Budget by Project
- Approve the CalOptima Health Fiscal Year 2025-26 Covered California Capital Budget, allocate up to $3.72 million from existing reserves to fund pre-implementation expenditures related to Covered California, and authorize expenditures and appropriate funds for the items in Attachment A1: Fiscal Year 2025-26 Covered California Capital Budget by Project
- Approve the CalOptima Health Fiscal Year 2025-26 Digital Transformation Year Four Capital Budget, extend the Digital Transformation Strategy for two years, through June 30, 2027, to complete ongoing and new projects, and authorize expenditures and appropriate funds for the items in Attachment A2: Update to Digital Transformation Years One through Three and Year Four Capital Budgets by Project

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

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

Contact
Donna Laverdiere, Executive Director, Strategic Development, (714) 986-6981

Recommended Action
Authorize 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.

Background
On August 1, 2024, the CalOptima Health Board of Directors (Board) authorized the Chief Executive Officer (CEO) to convene a stakeholder steering committee composed of key external partners and providers to discuss considerations for potential participation in Covered California. CalOptima Health leadership and staff convened the Covered California Stakeholder Steering Committee, which has met on nine separate occasions. On October 3, 2024, the Board directed the CEO to request the Orange County Board of Supervisors (BOS) to amend CalOptima Health's governing ordinance to remove the prohibition on participation in Covered California. On January 14, 2025, the BOS unanimously voted to amend the ordinance to allow CalOptima Health's participation in Covered California. On December 5, 2024, the Board approved actions related to Covered California consulting support contracts and associated funding.

CalOptima Health must obtain approval to operate a Covered California product under its Knox-Keene Act license from the California Department of Managed Health Care (DMHC). Obtaining a Knox-Keene Act license or expanding an existing license is a regulatory filing process that all plans must comply with to offer an individual market health plan. While CalOptima Health is currently licensed with DMHC for the OneCare Medicare product, CalOptima Health must submit a filing to expand its current Knox-Keene Act license to participate in the individual market. As a first step in this process, CalOptima Health participated in a pre-filing conference with DMHC on February 25, 2025.

Discussion
The DMHC filing process is a multi-phased process that CalOptima Health must complete by early 2026 to obtain the proper approvals to operate an individual market health plan. The process requires the submission of at least 89 supporting exhibits that demonstrate compliance with the requirements of the Knox-Keene Act. Over the course of the filing and review process, CalOptima Health will receive feedback and requests for revisions from DMHC and will respond in a timely manner. If the submission and review process is completed successfully, CalOptima Health will be granted approval under its existing license to participate in the individual market.

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If the Board approves the submission of a license expansion filing to DMHC, CalOptima Health plans to submit the required documentation to DMHC in three phases, subject to change as the process proceeds. This phased approach is a regular component of the filing process and allows CalOptima Health to develop the necessary submission materials and requested information.

- Initial DMHC filing submission: June 16, 2025.
- Second DMHC filing submission: October 15, 2025.
- Third DMHC filing submission, February 15, 2026.

The types of documents that are required to be filed are summarized below. A complete list of the exhibits that would be submitted to DMHC is included in Attachment 1.

Type of Exhibit	Description of Documentation
Organizational Documents	• Organizational charts. • Statements of key management duties and resumes.
Legal Documents	• Narrative summaries describing plan organization and operations. • Bylaws • Summary of any relevant criminal, civil, and administrative proceedings. • Demonstration of compliance with Knox-Keene Act requirements.
Clinical Operations	• Policies related to coordination of care and referral processes. • Utilization management program description and committee structure.
Core Operations	• Descriptions of provider claims payment processes. • Policies related to language access, grievance procedures, and grievance forms.
Quality	• Quality of care review system. • Policies describing quality assurance administration by providers, provider credentialing and re-credentialing, and timely access.
Compliance	• Fraud, waste, and abuse plan. • Policies demonstrating compliance with the California Confidentiality of Medical Information Act.
Provider Network	• Provider and facility rosters and ratios. • Policies describing standards of accessibility, provider directory development and monitoring, and provider oversight and monitoring procedures. • Copies of provider contracts.
Administrative Contracts	• List of contracts with affiliated persons, principal creditors, and administrative service providers. • Templates and executed contracts for all administrative, management, or consulting contractors that will support the Covered California product.

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Sales & Marketing	• Marketing statement and any advertisements used to market the Covered California product (to be filed in 2026).
Finance	• Enrollment projections. • Financial projections. • Financial statements.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact.

Rationale for Recommendation
The recommended action will allow CalOptima Health to file a license application with DMHC to expand its Knox-Keene Act license to operate an individual market health plan as part of Covered California.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Required Exhibits for DMHC Knox-Keene Act Licensing Submission for Covered California Participation

/s/ Michael Hunn *05/30/2025*
Authorized Signature **Date**

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Attachment 1:
Required Exhibits for DMHC Knox-Keene Act Licensing Submission for Covered California Participation

Exhibit Number	Exhibit Summary	Exhibit Details	Materials to Satisfy Exhibit Requirements	Initial Filing (June 2025)
AA	Marketing Contracts Supervision P&P	Policy should describe "internal arrangements to supervise the marketing of its plan contracts, including the name and title of each person who has primary management responsibility for the employment and qualification of solicitors, advertising, contracts with solicitors and solicitor firms and for monitoring and supervising compliance with contractual and regulatory provisions."	Policy to be developed and provided in 2026.	
BB-1	Solicitation Contracts	Provide a list of all persons (other than any employee of the Plan whose only compensation is by salary) soliciting or agreeing to solicit the sale of contracts on behalf of the Plan. For each such person, identify by exhibit number that person's contract furnished pursuant to Item BB-2 and, if such contract does not show the rate of compensation to be paid, specify the person's rate of compensation.	List of entities that will be signing up Covered California members. To be provided in 2026.	
BB-2	Solicitation Contracts	Submit a copy of each contract or proposed contract between the Plan and the persons named in Exhibit BB-1 for soliciting the sale of or selling contracts on behalf of the Plan. If a standard form contract is used, furnish a specimen of the form, identify the provision and terms of the form which may be varied and include a copy of each variation.	Contracts for entities that will be signing up Covered California members. To be provided in 2026.	
CC-001	Coordination of Care P&P	Policy covering the continuity, timeliness and coordination of care between and among providers (including mental health providers, specialists, facilities, medical groups, case management staff, etc.); timely communication of clinical information among providers; transitions of care; co-payments, deductibles, or other cost sharing requirements during the period of a completion of covered services with a terminated provider or a nonparticipating provider; specialty referrals. H&S Code §§ 1367(d), 1368.016(a)(6), 1373.95, 1373.96; 28 CCR §§ 1300.67.1(c)-(e), 1300.70(a)(1)-(3), 1300.80(b)(4).	1. [New]CC.1500: Continuity of Care for Members Transitioning into CalOptima Health Services (Clinical) 2. [New]CC.1501: Continuity of Care During Health Network or Provider Termination (Clinical) 3. [New]CC.1300: Block transfer (Customer Service)	✓
D-2	Other Agency Filings	Summarizes approvals needed from other agencies and the status of those approvals.	Summary of other filings	
E-1	Summary Plan Organization and Operations	Provide as Exhibit E-1 a summary description of the organization and operation of applicant's business as a health care service plan, covering the highlights and essential features of the information provided in response to the other portions of this application which is essential or desirable to an effective overview of the applicant health care service plan business.	Narrative summary of CalOptima Health's filing	✓
E-2	Summary Description of Start-Up	Concise description of applicant's start-up program and its assumptions. Indicate applicant's projected date for beginning of plan operations.	Narrative start-up plan for CalOptima Health's Covered CA product	✓
EE	Enrollment Projections	Total enrollment projections for the plan on a monthly basis for the first year and quarterly basis for the second year. Projected periods should align with financial information filed under Exhibit HH-2.	Enrollment projections developed by actuary	✓
F-1-a-i	Articles of Incorporation	Articles of Incorporation	Exhibit E-1 will reference CalOptima Health's enacting ordinance and statue.	✓
F-1-a-ii	Bylaws	Bylaws	CalOptima Health organizational bylaws	✓

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Attachment 1:
Required Exhibits for DMHC Knox-Keene Act Licensing Submission for Covered California Participation

Exhibit Number	Exhibit Summary	Exhibit Details	Materials to Satisfy Exhibit Requirements	Initial Filing (June 2025)
F-1-a-iii	Corporate Information Form	Details corporate information, including ownership, officers, and board members	Summary of CalOptima Health corporate information	✓
F-1-f	Individual Information Sheets	Required for each key personnel member listed on Exhibit L-1	Currently on file with DMHC. Refer reviewers to DMHC Filing No. 20250670, dated 3/17/25.	✓
F-2-a	List of contracts with affiliated persons, principal creditors, administrative service providers	Includes type of contract or loan, the relationship of the entities	CalOptima Health does not have lists/relationships to disclose. Will file to be responsive to requirements, per legal counsel.	✓
F-2-b	Surplus Notes and Subordination Agreements	Copies of contracts listed in F-2-a (excluding ASAs, which are filed under Ex. N-1)	Copy of contracts, to be provided in 2026	✓
F-3	Other Controlling Persons	Any entity not named in other exhibits with power, directly or indirectly, to manage, influence, or administer the operation, or to control the operations or decisions of applicant	CalOptima Health does not have lists/relationships to disclose. Will file to be responsive to requirements, per legal counsel.	✓
F-4	Criminal, civil and administrative proceedings	Within the preceding 10 years, has the applicant, its management company, or any Affiliate of the applicant (Rule 1300.45(c)), or any controlling person, officer, director or other person occupying a principal management or supervisory position in such plan, management company or Affiliate, or any person intended to hold such a relationship or position, been convicted of or pleaded nolo contendere to a crime, or been held to have committed any act involving dishonesty, fraud or deceit in a judicial or administrative proceeding to which such person was a party?	Will file summary per legal counsel.	✓
FF-1	Determination of Prepaid Charges	A description of the method used by applicant to determine the prepaid or periodic charges fixed for individual contracts, including the method by which administrative and other indirect costs are allocated. Describe the facts and assumptions upon which such charges are based (e.g., contract mix, family size) and furnish supporting documentation to substantiate the validity of the facts and assumptions used.	Narrative description	
FF-2-b	Schedule of Prepaid Charges	A schedule of the prepaid or periodic charges assessed subscribers under each individual contract.	Schedule, to be provided in 2026.	
FF-3	Collection of Prepaid Charges	A description of the manner in which applicant will collect prepaid and periodic charges and copayments from subscribers and enrollees under its individual contracts. If prepaid or periodic charges will be paid by subscribers to an entity other than the plan, identify the entity and specify the measures used by the plan to safeguard and account for such funds. See 28 CCR §§ 1300.76.2, 1300.85 and 1300.85.1.	Description, to be provided in 2026.	
G-1	Consent to Service of Process		Currently on file with DMHC	

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Attachment 1:
Required Exhibits for DMHC Knox-Keene Act Licensing Submission for Covered California Participation

Exhibit Number	Exhibit Summary	Exhibit Details	Materials to Satisfy Exhibit Requirements	Initial Filing (June 2025)
G-2	Disclosure of Financial Information	Authorizations for the disclosure of financial records of the applicant, and of any association, partnership or corporation controlling, controlled by or otherwise affiliated with the applicant	Currently on file with DMHC	
GG	Financial Statements	Audited statements for the previous fiscal year and unaudited statements for the time period in between the end of the fiscal year and the filing. TNE calculations are under 28 C.C.R. § 1300.76.	Audited statements	✓
H-1	Description of Service Area	Narrative and description of proposed service area.	Description of Orange County service area	
H-2	Map of Service Area	Printed map of service area	This exhibit is optional	
HH-1	Pre-Operation Financial Projections	Financial projections pre-operation to the start-up date	Financial projections	✓
HH-2	Post-Operation Financial Projections	Financial projections post-operation on a monthly basis for the first year and quarterly basis for the second year, including balance sheets, income statements, statements of cash flows, calculation of TNE pursuant to 28 CCR § 1300.76, and calculation of administrative percentage pursuant to 28 CCR § 1300.78.	Financial projections	✓
HH-3	Substantiation of Projections	Substantiation of Projections in HH-1 and HH-2 with Feasibility studies obtained by applicant as normally required by conventional lending institutions, including at least (i) legal, marketing/enrollment, providers and financial, and (ii) actuarial report, which includes at least the following: utilization rates, cost per utilization unit, per member per month cost, methodology and source of data used, and inflation estimates.	Financial projections	✓
HH-4	Reimbursement Projections	a. Monthly and quarterly projections for each of the following: (i) Payments to reimburse noncontracting providers for covered health care services furnished to enrollees. (ii) Payments to reimburse enrollees for covered health care services furnished by noncontracting providers. (iii) Total reimbursements for services by noncontracting providers (1) plus (2). (iv) Fee-for-service payments to reimburse contracting providers for covered health care services. (v) Total reimbursements (3) plus (4). (vi) Total expenditures by applicant for covered health care services. (vii) The ratio of total reimbursements to total health care expenditures (5) divided by (6). (viii) The ratio of reimbursements for services by noncontracting providers to total expenditures (3) divided by (6). b. Describe and substantiate the facts and assumptions upon which the projections are based, including those for fee-for-service payments to contracting providers and document the source and validity of such assumptions. (Actuarial studies or comparable information should be furnished in response to these items.) c. If the ratio of total reimbursements to total expenditures in HH-4-a(viii) exceeds 10%, specify the measures by which applicant will comply with H&S Code § 1377(a) and 28 CCR §§ 1300.77, 1300.77.3. If applicant will maintain reserves as specified in H&S Code § 1377(a)(1), specify the size of the reserve and the fiscal impact upon applicant arising from its maintenance. d. If the ratio of total reimbursements to total expenditures in HH-4-a(vii) exceeds 10%, specify the measures by which applicant will comply with H&S Code § 1377(b) and 28 CCR §§ 1300.77.1, 1300.77.2 and 1300.77.3.	Financial projections	✓

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Attachment 1:
Required Exhibits for DMHC Knox-Keene Act Licensing Submission for Covered California Participation

Exhibit Number	Exhibit Summary	Exhibit Details	Materials to Satisfy Exhibit Requirements	Initial Filing (June 2025)
HH-5	Administrative Cost Projections	If applicant's administrative costs (as defined in 28 CCR § 1300.78) as projected for its initial period of operation exceed 25% of the prepaid or periodic charges paid by or on behalf of subscribers, and if such administrative costs exceed 20% of such charges for the following year, include a calculation of the percentage of administrative costs to such charges for both such periods and furnish information which explains the necessity for the level of administrative costs projected and the manner in which applicant will reduce such costs to not more than 15% of such charges within five years after licensure.	Financial projections	✓
HH-6	Provision for Extraordinary Costs	a. Evidence of adequate insurance coverage or self-insurance to respond to claims for damages arising out of furnishing health care services. b. Evidence of adequate insurance coverage or self-insurance to respond to claims for tort claims, other than with respect to claims for damages arising out of furnishing health care services. c. Evidence of adequate insurance coverage or self-insurance to protect applicant against losses of facilities upon which it has the risk of loss due to fire or other causes. Identify facilities covered by individual policies and indicate the basis upon which applicant believes that the insurance thereon is adequate. d. Evidence of fidelity bond coverage for at least the amounts specified in 28 CCR § 1300.76.3, in the form of a primary commercial blanket bond or a blanket position bond written by an insurer licensed by the California Insurance Commissioner, providing 30 days' notice to the DMHC prior to cancellation, and covering each officer, director, trustee, partner and employee of the plan, whether or not compensated. e. Evidence of adequate workers' compensation insurance coverage against claims which may arise against applicant.	Materials provided by actuary	✓
I-1	Individual Physicians	Full network roster	Roster of contracted providers	
I-1	Telehealth Providers	List of telehealth-only providers	Roster of contracted providers	
I-2	Hospitals	List of contracted hospitals	Roster of contracted hospitals	
I-3	Other Providers	List of ancillary providers	Roster of contracted ancillary providers	
I-4	Provider-Enrollee Ratios / Projections	Ratios of PCPs to enrollees, specialists to enrollees, and combined providers to enrollees, as well as enrollment projections by county and line of business for 2 years following entry into the service area	Enrollment projections and ratios provided by actuary	
I-5	Standards of Accessibility	Detailed description of the applicant's standards with respect to accessibility and its procedures for monitoring. Include: 1. Availability of appointments for PCP and specialist 2. Availability of after hours and emergency services 3. Assessment of probable patient waiting times 4. Proximity of specialist and hospitals to sources of primary care 5. Description of monitoring accessibility 6. Any contractual arrangements utilized by the applicant	1. [New] CC.1700: Standards of Accessibility and Timely Access	✓

Attachment 1:
Required Exhibits for DMHC Knox-Keene Act Licensing Submission for Covered California Participation

Exhibit Number	Exhibit Summary	Exhibit Details	Materials to Satisfy Exhibit Requirements	Initial Filing (June 2025)
I-6	Referral Process P&P	Description of applicant's referral process, including: 1. Referral P&P 2. Follow-up on referrals, including turnaround times 3. Policy for paying noncontracted providers (Claims)	1. [New] CC.1600: Authorization and Processing of Referrals 2. [New] CC.1001: Claims processing for Covered Services 3. [Revised] GG.1112: Standing Referral to Specialty Care Provider or Specialty Care Center	✓
I-7	Provider Notices	Any notices provided to providers as part of the Covered California licensing process	Any relevant provider notices	
I-9	Member Notices	Any notices provided to members as part of the Covered California licensing process	Any relevant member notices	
II-1	Maintenance of Financial Viability	A statement describing applicant's arrangements to comply with H&S Code § 1375.1(b) and 28 CCR § 1300.75.1(a)(2). If applicant will maintain insurance under these provisions, furnish a specimen of the policy, the name of the insurer and the premium cost of the policy.	Currently on file with DMHC as of 05/29/14, filing number 20141156. Will file update for Covered CA product.	✓
II-2	Capitation Payments to Providers	A statement indicating the percentage of contracting providers who will be compensated on a capitated basis, a description of the method used to determine and adjust the capitation rates, and substantiate by means of calculations or other information that such capitation rates are adequate to reasonably assure the continuance of the applicant/provider relationship.	Currently on file with DMHC as of 05/29/14, filing number 20141156. Will file update for Covered CA product.	
II-3	Risk of Insolvency	A description of the manner in which applicant will provide for each of the following in the event of applicant's insolvency: (i) the continuance of benefits to enrollees for the duration of the contract period for which payment has been made, (ii) the continuance of benefits to enrollees until their discharge, for those enrollees confined in an in-patient health care facility on the date of insolvency, and (iii) payments to noncontracting providers for services rendered.	Currently on file with DMHC as of 05/29/14, filing number 20141156. Will file update for Covered CA product.	✓
II-4	Provider Claims	A statement describing applicant's system for processing claims from contracting providers and noncontracting providers for payment, and from subscribers and enrollees for reimbursement, including the rules defining applicant's obligation to reimburse, the standards and procedures for applicant's claims processing system (including receipt, identification, handling, screening, and payment of claims), the timetable for processing claims, procedures for monitoring the claims processing system, and procedures for reviewing the claims processing system in view of complaint from contracting or noncontracting providers or grievances from subscribers or enrollees.	1. [New] CC.1001: Claims processing for Covered Services 2. [Desktop Procedure] Claims	✓
II-5	Other Business	If the applicant is or will engage in any business other than as a health care service plan, include a statement describing such other business, its relationship to applicant's business as a plan, and the anticipated financial risks and liabilities of such other business.	Currently on file with DMHC as of 05/29/14, filing number 20141156	✓
II-7	Reimbursement Rate Determination	Submit policies and procedures for determining the average contracted rate; default reimbursement rate in accordance with Section 1300.71.31.	Policy to be developed and provided in late 2025	

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Attachment 1:
Required Exhibits for DMHC Knox-Keene Act Licensing Submission for Covered California Participation

Exhibit Number	Exhibit Summary	Exhibit Details	Materials to Satisfy Exhibit Requirements	Initial Filing (June 2025)
J-01	Quality of Care Review System	Organization and Operation - description of the basic structure, organization and authority of the applicant's quality of care review system, including: 1a. Org chart showing key persons, committee and bodies responsible for the conduct of the system, and provisions of support staff. 1b. Narrative of explanation of the review system covering the matters depicted in the organization chart and the following: key persons involved, titles and qualifications, and extent of support staff.	1. [Revised] GG 1611: Potential Quality Issue, Review Process 2. [Revised] GG 1616: Fair Hearing Process 3. [Revised] GG 1607: Monitoring Adverse Actions 4. [Revised] GG.1658_Summary Suspension of Restriction of Practitioner Participation in CalOptima Health's Network (Peer Review) 5. [Revised] GG.1657_State Licensing Board and the National Practitioner Data Bank (NPDB Reporting) (Peer Review) 6. [Revised] GG 1620: Quality Improvement Health Equity Committee (QIHEC) 7. [Revised] GG 1629: Quality Improvement and Health Equity Transformation Program (QIHETP) 8. (Updated) QA Plan, including org chart	✓
J-02	Quality Review - Standards and Norms	Description of the standards and norms of the system, and indicate how these standards and norms will be communicated to providers.	1. [Revised] GG 1629: Quality Improvement and Health Equity Transformation Program (QIHETP) 2. [Revised] GG 1620: Quality Improvement Health Equity Committee (QIHEC) 3. [Revised] GG 1607: Monitoring Adverse Actions	✓
J-03	Quality Review - Operation of System	Description of the operation of review system, including the frequency and scope of audits, utilization of the audit results and the procedures and methods for enforcement of the standard and norms of the system.	1. [Revised] GG 1607: Monitoring Adverse Actions 2. [Revised] GG 1611: Potential Quality Issue, Review Process 3. [Revised] GG 1616: Fair Hearing Process 4. [Revised] GG 1619: Delegation Oversight (Delegation Oversight) 5. [Revised] GG 1620: Quality Improvement Health Equity Committee (QIHEC) 6. [Revised] GG 1629: Quality Improvement and Health Equity Transformation Program (QIHETP) 7. [Revised] GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB Reporting) (Peer Review) 8. [Revised] GG.1658: Summary Suspension of Restriction of Practitioner Participation in CalOptima Health's Network (Peer Review)	✓

Attachment 1:
Required Exhibits for DMHC Knox-Keene Act Licensing Submission for Covered California Participation

Exhibit Number	Exhibit Summary	Exhibit Details	Materials to Satisfy Exhibit Requirements	Initial Filing (June 2025)
J-04	Quality Assurance Administration by Providers	If portions of the review system are administered by contracting providers, by affiliates of the applicant or by other persons who are not officers or employees of the applicant, this exhibit identifies those portions of the system together with the providers, affiliates or persons administering them on behalf of the applicant.	1. [Revised] GG 1607: Monitoring Adverse Actions 2. [Revised] GG 1611: Potential Quality Issue, Review Process 3. [Revised] GG 1616: Fair Hearing Process 4. [Revised] GG 1619: Delegation Oversight (Delegation Oversight) 5. [Revised] GG 1620: Quality Improvement Health Equity Committee (QIHEC) 6. [Revised] GG 1629: Quality Improvement and Health Equity Transformation Program (QIHETP) 7. [Revised] GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB Reporting) (Peer Review) 8. [Revised] GG.1658: Summary Suspension of Restriction of Practitioner Participation in CalOptima Health's Network (Peer Review)	✓
J-05	Quality Assurance Monitor Process	Description of the contractual arrangements which will be employed to enable the plan to monitor, and require, compliance with the quality of care review system, to the extent such system is administered by such contracting providers.	1. [Revised] GG 1611: Potential Quality Issue, Review Process 2. [Revised] GG 1616: Fair Hearing Process 3. [Revised] GG 1629: Quality Improvement and Health Equity Transformation Program (QIHETP) 4. [Revised] GG 1620: Quality Improvement Health Equity Committee (QIHEC) 5. [Revised] GG 1607: Monitoring Adverse Actions	✓
J-05-a	Provider Credentialing, Contract, and Re-Credentialing Policies and Procedures	Policy to ensure that providers comply with credentialing requirements under all applicable federal, state, and local laws, rules, and regulations.	1. [Revised] GG.1650: Provider Credentialing 2.[Revised] GG.1651: Assessment and Reassessment of Organizational Providers 3. [Revised] GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities (Credentialing)	✓
J-08	Anti-Fraud Plan	Established in accordance with H&S Code § 1348	1. [Revised] HH.1105: Fraud, Waste, and Abuse Detection 2. [Revised] HH.1107: Fraud, Waste, and Abuse Investigation and Reporting 3. [Revised] HH.5000: Provider Overpayment Investigation and Determination 4. [Revised] HH.5004: False Claims Act Education	✓

Attachment 1:
Required Exhibits for DMHC Knox-Keene Act Licensing Submission for Covered California Participation

Exhibit Number	Exhibit Summary	Exhibit Details	Materials to Satisfy Exhibit Requirements	Initial Filing (June 2025)
J-09-a	UM Program Description	Description of the utilization management program, including coordinating benefits; criteria for decisions; policies for referrals, denials, authorizations, and second opinions; and concurrent and retrospective review.	1. [New] CC.1400: Behavioral Health Services 2. [New] CC.1600: Authorization and Processing of Referrals 3. [Revised] GG.1112: Standing Referral to Specialty Care Provider or Specialty Care Center 4. [Revised] GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization 5. [Revised] GG.1541: Utilization Management Delegation 6. [Revised] GG.1535: Utilization Review Criteria and Guidelines 7. Utilization Management Program Plan	✓
J-09-b	UM Committee Structure	Description of committee structure.	Utilization Management Program Plan	✓
J-10	Language Access P&P	Policy detailing compliance with H&S Code § 1367.04 and 28 CCR § 1300.67.04, including: a. To ensure that qualified interpreter services are available at all member points of contact; b. To define processes to monitor compliance with various state and federal requirements surrounding the provision of qualified interpreter services.	1. [Revised] DD.2002: Cultural and Linguistic Services [Customer Service]	✓
J-13	Timely Access P&P	Detailed description of the standards with respect to accessibility and its procedures for monitoring the accessibility of services.	1. [New] CC.1700: Standards of Accessibility and Timely Access	✓
J-14	Provider Directory P&P	Policy and procedure to reflect APL 24-006 and H&S Code § 1367.27.	1. [Revised] EE.1146: Provider Directory	✓
J-17	Emergency Declaration P&P	Sets forth procedures when a state of emergency and health emergency is declared, in accordance with H&S Code § 1368.7 and DMHC APL 23-002.	1. [New] CC.2000: Emergency Declaration	✓
J-18	CMIA Requirements Policy	Policy for compliance with the California Confidentiality of Medical Information Act and AB 1184.	1. [Revised] HH.3024: Confidentiality of Medical Information Act Compliance	✓
J-23	Health Equity and Quality Contact	The name, title, phone number, and email address of the health plan's Health Equity and Quality Contact.	Currently on file with DMHC as of 08/27/24, filing No. 20243720.	✓
J-24	Enforcement Matter Contact	The name, title, phone number, and email address of the health plan's Enforcement Matter Contact.	Currently on file with DMHC as of 08/27/24, filing No. 20243720.	✓
J-25	Cyber Security Incident Contact	The name, title, phone number, and email address of the health plan's Cyber Security Incident Contact.	Currently on file with DMHC as of 08/27/24, filing No. 20243720.	✓
K-1	Copies of Provider Contracts	Copy of each template provider contract and unique provider contracts.	Provider contract templates to be submitted in initial filing (June 2025). Executed provider contracts to be submitted in early 2026 for DMHC review.	✓

Attachment 1:
Required Exhibits for DMHC Knox-Keene Act Licensing Submission for Covered California Participation

Exhibit Number	Exhibit Summary	Exhibit Details	Materials to Satisfy Exhibit Requirements	Initial Filing (June 2025)
K-2	Compliance Requirements	Statement in tabular form for each provider contract specifying the provisions of such contract complies with DMHC provider contract checklist.	Provider contract checklist and crosswalk, completed within DMHC portal.	✓
K-3	Compensation of Health Care Providers	One copy of the following provisions clearly marked "confidential": 1. Title page of contract 2. Effective date and expiration date 3. Mechanism of payment to provider 4. Signature page	Contract Provisions	
L	Organization Chart	CalOptima Health organizational chart including key personnel	Currently on file with DMHC as of 2/13/25, filing no. 20250670.	✓
M-1	Narrative of Org Chart	Narrative explanation of org chart	Currently on file with DMHC as of 12/13/24, filing no. 20245528.	✓
M-2	Individual Statements	Statement of each individual who is a member of a board, committee or who occupies position in org chart covering principle responsibilities of each person and time devoted to each position.	Currently on file with DMHC as of 2/13/25, filing no. 20250670. This exhibit is filed as combined document with Exhibit M-2 & M-3.	✓
M-3	Key Management Duties	Primary duties and responsibilities of those persons who occupy the positions specified in Exhibits L-1, M-1, and M-2.	Currently on file with DMHC as of 2/13/25, filing no. 20250670. This exhibit is filed as combined document with Exhibit M-2 & M-3.	✓
M-5	Redacted Resumes (Public)	For key personnel named in Exhibits L and M-1.	Currently on file with DMHC as of 3/17/25, filing no. 20250670.	✓
MSC04 (RFC)	Request for Confidentiality	The Plan should file a public Request for Confidentiality for any exhibit which confidentiality is requested, if applicable. The request must comply with section 1007 of title 28 of the California Code of Regulations.	Confidentiality request	✓
N-1	Administrative Services Agreement (ASA)	Copy of each template ASA contract and unique ASA contracts.	1. ASA Templates to be submitted in initial filing (June 2025) 2. Executed Contracts to be submitted early 2026	✓
N-3	Claims Processing Contract	File an Exhibit N-3 for each claims processing contract that is either new or amended, if applicable.	Narrative description of claims processing approach	✓
N-5	Oversight and Monitoring Procedures	A policy and procedure detailing how the Plan oversees and monitors each of its administrative services vendors.	1. [New] CC.1100: Oversight of Administrative Vendors 2. Vendor-specific monitoring policies to be submitted early 2026	✓

Attachment 1:
Required Exhibits for DMHC Knox-Keene Act Licensing Submission for Covered California Participation

Exhibit Number	Exhibit Summary	Exhibit Details	Materials to Satisfy Exhibit Requirements	Initial Filing (June 2025)
O	Medical and Fiscal Services Statement	Statement describing how the plan will provide for separation of medical and fiscal management to assure that medical decisions will not be influenced by fiscal. Describe the controls and refer to items in Ex Js.	Narrative statement	✓
P-5	Plan-to-Plan Contracts	Each plan-to-plan contract with DMHC licensees which is either new or amended as a result of the proposed service area expansion, if applicable.	Copy of VSP and Liberty Dental contracts	
Q-1	Individual Plan Contracts	The contracts CalOptima will use for individual subscribers on the Exchange.	Will submit sample EOCs and subscriber agreements.	
Q-3	Compliance Requirements	A table showing Ex. Q-1's compliance with Knox Keene Act requirements.	Crosswalk demonstrating Knox Keene Act requirements	
R-4	Plan-to-Plan Contract DOFRs	Describe, using DMHC template, the division of responsibility with each licensed full service health care service plan with which CalOptima will contract.	Populated DMHC template	
U-1	Combined Evidence of Coverage and Disclosure Forms	Each combined evidence of coverage and disclosure form should relate to one form of plan contract; however, a combined evidence of coverage and disclosure form offering alternative plans or options will be permitted if presented in a manner which clearly identifies the alternatives and their effect upon the contract.	Will submit template EOC and disclosure forms	
V	Advertisements	Any written or printed communication or any communication by means of recorded telephone messages or by radio, television, or similar communications media, published in connection with the offer or sale of plan contracts, and these filings must also identify to which products the advertisement relates and the segment of the public to which they will be directed.	Advertisements or media materials. To be filed in 2026.	
W-1	Enrollee Grievance Procedures	Procedure to comply with H&S Code § 1368 and 28 CCR §§ 1300.68, 1300.85 and 1300.85.1.	1. [New] CC.1201: Member Grievances 2. [New] CC.1200: Member Appeals	✓
W-11	Health Plan Grievance Staff Contacts	The plan representative whom the DMHC should contact regarding grievance questions.	Currently only file with DMHC as of 08/27/24, filing no. 20243720	✓
W-13	Health Plan Provider Dispute Contacts	The plan representative whom the DMHC should contact regarding provider complaint questions.	CalOptima Health staff contact will be provided.	✓
W-2	Enrollee Grievance Forms	Grievance letters and forms, including acknowledgement and resolution letters, in all threshold languages.	CalOptima Health will provide the following letters: (1) Acknowledgement of grievance; (2) Resolution of Standard grievance; (3) Resolution of urgent grievance; (4) Acknowledgement of Appeal; (5) Resolution of Appeal	✓
W-3	Grievance Oversight Staff	List of roles in the GARS Department	Organizational chart	✓

Attachment 1:
Required Exhibits for DMHC Knox-Keene Act Licensing Submission for Covered California Participation

Exhibit Number	Exhibit Summary	Exhibit Details	Materials to Satisfy Exhibit Requirements	Initial Filing (June 2025)
W-4	Grievance Oversight Staff Duties	List of job descriptions for GARS Department	Job descriptions	✓
Z	Marketing of Individual Contracts	A statement describing the methods by which applicant proposes to market individual plan contracts, including the use of employee or contracting solicitors or solicitor firms, their method or form of compensation and the methods by which applicant will obtain compliance with 28 CCR § 1300.59, 1300.61, 1300.76.2, and 1300.85.1.	Summary of marketing approach. To be provided in 2026.	

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

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

Contact

Donna Laverdiere, Executive Director, Strategic Development (714) 986-6981

Recommended Action

1. Authorize closing the following Board-approved initiatives and transfer 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. Authorize closing Board-approved Intergovernmental Transfers 1, 3, 5, 6, and 7 initiatives, as listed in Table 1 below, and designate the remaining balance of $848,924 as available for allocation to deliver enhanced services for Medi-Cal members.
3. Authorize closing Board-approved Intergovernmental Transfers 8, 9, and 10 initiatives, as listed in Table 2 below, and transfer the remaining funds of $9,037,981 to unallocated reserves to deliver covered services for Medi-Cal members.

Background/Discussion

In accordance with CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds, the CalOptima Health Board of Directors (Board) reviews the levels of total assets and the Board-designated Reserve Fund, at minimum, on an annual basis, including during the development of the strategic plan and the preparation of the annual operating budget. This review allows the Board to assess resources to be used for the purposes of expanding access to care, improving member benefits, or augmenting provider reimbursement.

In conjunction with preparing the Fiscal Year (FY) 2025-26 Operating Budget, staff reviewed the status of Board-approved initiatives to assess for those items that are completed, closed, or no longer needed. The recommended actions will provide the Board with a more accurate assessment of the level of total assets and return unused dollars to available IGT funds or unallocated reserves for future Board allocations.

Board-approved Initiatives Funded from Unallocated Reserves

Staff recommends closing the following Board-approved initiatives and transferring the remaining funds of $23,964,513, in aggregate, to unallocated reserves.

- OneCare Member Health Incentives: At the December 1, 2022, meeting, the Board approved the Calendar Year 2023 OneCare Member Health Rewards and Incentives Program and appropriated

an amount up to $500,000 from existing reserves to fund the program through June 30, 2023. This program has been fully implemented and has a remaining balance of $247,025.

- Temporary, Short-term Public Health Emergency Transition Supplemental Medi-Cal Rate Increases: At the June 1, 2023, meeting, the Board authorized a temporary, short-term Public Health Emergency transition supplemental Medi-Cal rate increase to providers and authorized unbudgeted expenditures from existing reserves in an amount up to $107.3 million, in aggregate. The increase was effective for the period of July 1, 2023, through August 31, 2024. The rate increase was fully implemented, with a remaining balance of $6,106,830.

- Proposed Community Living and PACE Center in the City of Tustin: At the February 2, 2023, meeting, the Board authorized actions related to the Proposed Community Living and PACE Center in the City of Tustin. The Board actions included authorizing:
    - A sole source contract with Totum Corporation; and
    - A formal procurement for a contract for general contractor services and furniture, fixtures, and equipment.

  In addition, the Board authorized unbudgeted expenditures of up to $18 million in undesignated reserves to fund the contracts for services related to the Community Living and PACE Center in the City of Tustin.

  The contract with Totum Corporation was executed. However, by June 2023, it was clear that the proposed recuperative care, post-hospitalization housing, and PACE Center site in the City of Tustin did not have enough support by the Tustin Planning Commission to move forward. Since the authority in the February 2, 2023, Board action was specific to the City of Tustin, staff recommends moving the remaining balance of $17,610,658 to unallocated reserves.

Board-approved Initiatives Funded by Intergovernmental Transfers

Since Fiscal Year (FY) 2010-11, CalOptima Health has participated in the Voluntary Rate Range Intergovernmental Transfer (IGT) program. At the beginning of the program, CalOptima Health retained fifty percent (50%) of net proceeds to support an increase in new Medi-Cal members through enhanced benefits. In 2022, CalOptima Health reduced the amount of retained funds to an administrative fee of two percent (2%) of net proceeds to administer the program.

CalOptima Health's expenditures of IGT funds are for restricted, one-time purposes for the benefit of Medi-Cal members. For IGT 1 through IGT 7, funds were used to deliver enhanced services for Medi-Cal members (*i.e.*, services that are not included in CalOptima Health's contract with the Department of Health Care Services). For IGTs 8 and after, funds were used for Medi-Cal covered services for Medi-Cal members.

Staff recommends closing the IGT 1-7 initiatives listed below and designating the remaining balance of $848,924 as available for a future allocation to deliver enhanced services for Medi-Cal members.

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Table 1: IGT 1-7 Initiatives for Closure

IGTs 1-7	Project	Project Status	Balance Remaining
IGT 1	Shape Your Life Program	Completed	$19
IGT 3	Data Warehouse Expansion	Completed	$14,800
IGT 5	Primary Care Services and Program Addressing Social Determinants of Health	Completed	$11,488
IGT 6 & 7	Whole Child Model Assistance for Implementation & Development	Completed	$18
	Master Electronic Health Record System	No longer needed	$581,207
	IGT Program Administration	Completed	$1,008
	Integrate Children's Mental Health Services into Primary Care Settings	Completed	$221,675
	Expand Access to Outpatient Children's Mental Health Services	Completed	$18,709
		Total	**$848,924**

Staff recommends closing the IGT 8-10 initiatives listed below and transferring the remaining balance of $9,037,981 to unallocated reserves.

Table 2: IGT 8-10 Initiatives for Closure

IGTs 8-10	Project	Project Status	Balance Remaining
IGT 8	Vaccination Intervention and Member Incentive Strategy	Completed	$68,699
IGT 9	Hospital Data Exchange Incentive	No longer needed*	$2,000,000
	Virtual Care Strategy & Roadmap	Completed	$893,967
	Post-Acute Infection Prevention Quality Initiative	Completed	$675,033
	Whole Child Model Program	Completed	-
IGT 10	COVID-19 Vaccination Incentive Program CY 2021	Completed	$5,167,850
	COVID-19 Vaccination Incentive Program CY 2021 - Staffing	Completed	$232,432
		Total	**$9,037,981**

*The proposed activities were separately funded through operating expenses.

Fiscal Impact

Recommended actions #1 and #3 combined will increase the amount of unallocated reserves by $33,002,494.

Recommended action #2 will make $848,924 in IGT funds available toward future IGT initiatives to deliver enhanced services for Medi-Cal members.

Rationale for Recommendation

Closure of Board-approved initiatives that are completed or no longer needed will provide the Board with a more accurate assessment of the level of net assets.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s/ Michael Hunn *05/30/2025*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Items

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

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 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.

Background and Discussion

OneCare is a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP), which coordinates Medicare and Medi-Cal benefits for beneficiaries eligible for Medicare and Medi-Cal (Duals). CalOptima Health's OneCare members may receive "Medi-Cal wrap-around services"; these are certain services and supports that are not covered by Medicare but are covered under the member's Medi-Cal program benefits.

To support CalOptima Health's OneCare program, CalOptima Health contracts with delegated health networks utilizing three (3) different contract risk models: Shared Risk Group, Physician Hospital Consortia, and Health Maintenance Organization. Each delegated health network, regardless of risk model, is contracted for both the OneCare and Medi-Cal programs.

Effective July 1, 2025, CalOptima Health desires to transition the cost of certain Medi-Cal wrap-around services, such as durable medical equipment/supplies, hospice, incontinence supplies, and non-emergency medical transportation, provided to CalOptima OneCare members to the health networks. This will be reflected in updated Medi-Cal capitation payment rates for services that will be the financial risk of the health networks. The financial risk will not include the Medi-Cal crossover claims or the following benefits or services: Behavioral Health, Community-Based Adult Services, CalAIM Community Supports, inpatient hospital, long term care, non-medical transportation, and hearing aids and supplies. CalOptima will retain this financial risk.

With this transition, CalOptima Health will accomplish three goals:

- Improve OneCare member experience by reducing member and provider abrasion, improve efficiency, and increase member and provider satisfaction;
- Improve provider experience by streamlining the claims process and mitigate confusion for billing providers; and

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- Align with Centers for Medicare and Medicaid Services and Department of Health Care Services goals for Medicare and Medicaid integration.

CalOptima Health formally introduced this change to the health networks in a special meeting in February 2025. Staff has continued discussions with the health networks through Health Network Forums and has provided additional education through provider communications.

To facilitate this change, CalOptima Health staff requests authority to execute amendments to the Medi-Cal and OneCare Program contracts with the health networks. The contract amendments will:

- Define the term "Medi-Cal wrap-around services;"
- Delegate responsibility of certain Medi-Cal wrap-around services for OneCare members to the health network;
- Update the health network's Medi-Cal capitation payment rates to reimburse for certain Medi-Cal wrap-around services that will be the financial risk of the health network; and
- Clarify the hearing aid benefit for OneCare members will continue to be the financial risk of CalOptima Health.

Fiscal Impact
The recommended action has no net fiscal impact. Staff anticipates a shift in medical expenses from fee-for-service to health network capitation payments that is not expected to exceed $2.0 million. Funding for projected medical expenses are included in the proposed Fiscal Year 2025-26 Operating Budget.

Rationale for Recommendation
The above recommended actions will support integrated member experience for CalOptima Health's OneCare members and improved provider experience with consistent authorization and billing processes for the health networks.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action
2. Medi-Cal Contract Amendment template
3. OneCare Contract Amendment templates (3)

/s/ Michael Hunn *05/29/2025*
Authorized Signature **Date**

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Attachment to the June 5, 2025, Board of Directors Meeting – Agenda Item 24

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Healthcare Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Care Medical Group	600 City Parkway West Ste. 800	Orange	CA	92868
Family Choice Health Services Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
Heritage Provider Network Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave.	Cypress	CA	90630
Monarch Health Plan, Inc.	1 Technology Dr.	Irvine	CA	92618
Prospect Health Plan Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

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AMENDMENT [XX] TO
THE CONTRACT FOR HEALTH CARE SERVICES

This Amendment [XX] to the Contract for Health Care Services ("**Amendment**") is effective as of July 1, 2025 ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency dba CalOptima Health, ("**CalOptima**"), and [Provider name] ("[**Physician/HMO/Hospital**]"). CalOptima and [Physician/HMO/Hospital] may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and [Physician/HMO/Hospital] entered into the Contract for Health Care Services, originally effective [date] ("**Contract**"), under which [Physician/HMO/Hospital] has agreed to provide or arrange for the provision of certain Covered Services to Medi-Cal Members.

B. CalOptima and [Physician/HMO/Hospital] are parties to a Medicare Advantage Physician Group Services Contract ("**MA Agreement**"), originally effective [date], for the provision of Medicare Advantage health care services to OneCare Members who are dually eligible to receive services payable by both Medicare and Medi-Cal Programs.

C. CalOptima desires to delegate to [Physician/HMO/Hospital] and [Physician/HMO/Hospital] desires to assume the responsibility for coordinating and paying for certain Medi-Cal wrap services under the Contract for those Members eligible for both Medi-Cal and Medicare services enrolled in CalOptima's OneCare Program.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Delete the Hearing Aids and Hearing Screening sections in Attachment [A], *CalOptima Medi-Cal Division of Financial Responsibility*, and replace it with the following section to clarify the financial responsibility for the hearing aid benefit for Medi-Cal wrap around services provided to OneCare Members:

	Physician		Hospital		Other
Hearing Aids, Supplies/Batteries, and Hearing Aid Screening	**X**				***CalOptima for Medi-Cal wrap around services for OneCare Members***

2. Add to the Contract a new section *Medi-Cal Wrap Around Services*, to Attachment [E], *Capitation Rates*:

> **Medi-Cal Wrap Around Services**.
> [Physician/HMO/Hospital] is responsible for coordinating, arranging for the provision of, and paying for certain Medi-Cal wrap around services, excluding Medi-Cal crossover

Draft pending board approval

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claims and the following benefits or services: Behavioral Health, Community-Based Adult Services, CalAIM Community Supports, Inpatient Hospital, Long Term Care, Non-Medical Transportation, hearing aids, supplies/batteries, and hearing aid screening ("**Excluded Medi-Cal Wrap Around Services**"), provided to CalOptima's OneCare Members who are dually eligible for such Covered Services under the Medi-Cal Program. CalOptima shall pay [Physician/HMO/Hospital] the following PMPM rate for Medi-Cal wrap around services that are the financial risk of [Physician/HMO/Hospital], excluding Excluded Medi-Cal Wrap Around Services in accordance with the Contract, further defined in Attachment A:

Services	Facility	Physician	Total Capitation
Medi-Cal Wrap Around Services	$X	$X	$X

3. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

4. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern.

5. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment.

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR [PHYSICIAN/HMO/HOSPITAL]:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

Draft pending board approval

AMENDMENT [XX] to
HMO SERVICES CONTRACT

This Amendment [XX] to the HMO Services Contract ("**Amendment**") is effective as of July 1, 2025 ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima Health ("**CalOptima**"), and [health network name] ("**HMO**"). CalOptima and HMO may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and HMO have entered into an HMO Services Contract, originally effective [insert date], ("**Contract**"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. The Parties desire to amend the Contract as provided herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Add the following new Section 1.6, *Medi-Cal Wrap-Around Services*, to Attachment C, *Capitation Rates and Risk Sharing*, of the Contract:

   1.6 **Medi-Cal Wrap-Around Services**. HMO shall be responsible for coordinating, arranging for the provision of, and paying for Medi-Cal Wrap-Around Services for Enrollees according to the terms and conditions of HMO's Medi-Cal contract with CalOptima. For purposes of this section, "**Medi-Cal Wrap-Around Services**" means the services and supports for an Enrollee that are not covered by Medicare but are covered under the Enrollee's Medi-Cal program benefits.

2. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

3. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

(*Signature page follows.*)

IN WITNESS WHEREOF, the Parties have executed this Amendment.

Draft pending board approval

FOR HMO:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

Draft pending board approval

AMENDMENT [XX] to
HOSPITAL SERVICES CONTRACT

This Amendment [XX] to the Hospital Services Contract ("**Amendment**") is effective as of July 1, 2025 ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima Health ("**CalOptima**"), and [Hospital name] ("**Hospital**"). CalOptima and Hospital may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and Hospital have entered into a Hospital Services Contract, originally effective [insert date], ("**Contract**"), by which Hospital has agreed to provide or arrange for the provision of Covered Services to Members.

B. The Parties desire to amend the Contract as provided herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Add the following new Section [1.6/1.4], *Medi-Cal Wrap-Around Services*, to Attachment C, *Capitation Rates and Risk Sharing*, of the Contract:

   [1.6/1.4] **Medi-Cal Wrap-Around Services**. Hospital shall be responsible for coordinating, arranging for the provision of, and paying for Medi-Cal Wrap-Around Services for Enrollees according to the terms and conditions of Hospital's Medi-Cal contract with CalOptima. For purposes of this section, "**Medi-Cal Wrap-Around Services**" means the services and supports for an Enrollee that are not covered by Medicare but are covered under the Enrollee's Medi-Cal program benefits.

2. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

3. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

(*Signature page follows.*)

Draft pending board approval

Back to Item

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR HOSPITAL:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

Draft pending board approval

AMENDMENT [XX] to
HOSPITAL SERVICES CONTRACT

This Amendment [XX] to the Hospital Services Contract ("**Amendment**") is effective as of July 1, 2025 ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima Health ("**CalOptima**"), and [Hospital name] ("**Hospital**"). CalOptima and Hospital may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and Hospital have entered into a Hospital Services Contract, originally effective [insert date], ("**Contract**"), by which Hospital has agreed to provide or arrange for the provision of Covered Services to Members.

B. The Parties desire to amend the Contract as provided herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Add the following new Section [1.6/1.4], *Medi-Cal Wrap-Around Services*, to Attachment C, *Capitation Rates and Risk Sharing*, of the Contract:

   [1.6/1.4] **Medi-Cal Wrap-Around Services**. Hospital shall be responsible for coordinating, arranging for the provision of, and paying for Medi-Cal Wrap-Around Services for Enrollees according to the terms and conditions of Hospital's Medi-Cal contract with CalOptima. For purposes of this section, "**Medi-Cal Wrap-Around Services**" means the services and supports for an Enrollee that are not covered by Medicare but are covered under the Enrollee's Medi-Cal program benefits.

2. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

3. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

(*Signature page follows.*)

Draft pending board approval

Back to Item

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR HOSPITAL:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

Draft pending board approval

Continued due to lack of in person quorum at the meeting location

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

25. 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 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.

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

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Attachments

1. Entities Covered by this Recommended Board Action
2. Medi-Cal FFS Hospital Services Contract Amendment

/s/ Michael Hunn *05/29/2025*
Authorized Signature **Date**

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Continued due to lack of in person quorum at the meeting location

Attachment to the June 5, 2025 Board of Directors Meeting – Agenda Item 25

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

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Continued due to lack of in person quorum at the meeting location



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

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Continued due to lack of in person quorum at the meeting location

Name	Address	City	State	Zip Code
Whittier Hospital Medical Center Inc. dba Whittier Hospital Medical Center	100 N. Stoneman Ave., 2nd floor, Managed Care Dept.	Alhambra	CA	91801

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 June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

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

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, Medical Management,714-246-8491
Linda Lee, Executive Director, Quality Improvement, (657) 900-1069
Javier Sanchez, Executive Director, Medicare Programs, (657) 235-6851

Recommended Actions

1. Authorize 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.
2. Approve the use of Measurement Year 2023 unearned Pay for Value funds for stipend costs in an amount not to exceed $150,000.

Background

Star Ratings are indicators of quality and access for the OneCare line of business and its membership, many of whom face complex medical conditions and socioeconomic challenges. Higher Star Ratings represent improved access to coordinated care, vital preventive services, and ultimately, demonstrably better health outcomes for the OneCare vulnerable population. Conversely, Star Ratings below minimum thresholds can lead to decreased enrollment, potential sanctions from the Centers for Medicare & Medicaid Services (CMS), and a diminished ability to attract and retain high-quality providers, ultimately jeopardizing the sustainability and effectiveness of the OneCare line of business.

The public availability of Star Ratings increases transparency in the Medicare market, empowering CalOptima Health members to make informed decisions about their healthcare coverage and hold plans accountable for the quality of their services. For CalOptima Health members, these ratings serve as a vital tool for gauging CalOptima Health's commitment to excellence and provide them with greater confidence in the quality of care they will receive. Recognizing the crucial role of CalOptima Health's provider network in achieving these high standards, staff has developed a comprehensive provider education program.

Discussion

To elevate CalOptima Health's Medicare Star Ratings, staff proposes hosting a comprehensive series of "Excellence in Care" educational events and offering meaningful stipends. The Excellence in Care educational program does not encourage or provide any incentive for patient referrals amongst providers or CalOptima Health. These strategically designed events will focus on equipping CalOptima Health network physicians and healthcare staff with strategies to tangibly enhance the quality-of-care delivery,

optimize clinical practice efficiency, and improve performance ratings. This proactive investment in the provider network is paramount to achieving and sustaining excellence in Medicare's Star Ratings.

By supporting providers' active participation in these critical educational events, CalOptima Health is proactively fostering a strong culture of continuous learning, open collaboration, and shared accountability. This focused education will equip network providers with the knowledge and tools necessary to directly impact the quality metrics that drive Star Ratings, ultimately leading to significant and sustained improvements in the overall quality of care delivered to OneCare members.

To encourage provider engagement and cultivate the strengthened partnership, vital for achieving enhanced Star Ratings, staff recommends that the Board of Directors authorize the Chief Executive Officer or their designee to strategically utilize available funding to offer stipends to providers in recognition of their time and commitment when attending CalOptima Health's Excellence in Care educational events. Staff recommends providing $200 stipends to each provider participating in the educational events and anticipates hosting up to 15 events between June 5, 2025, through June 30, 2026.

Fiscal Impact

The recommended action has no additional fiscal impact on the operating budget. Staff estimates that the cost of the stipends to providers for attendance at Excellence in Care educational events from June 5, 2025, through June 30, 2026, is approximately $150,000.

The balance of Measurement Year (MY) 2023 OneCare Pay for Value (P4V) Performance Program unearned funds available for allocation is $484,000. Unearned funds from the MY 2023 OneCare P4V Performance Program will be sufficient to fund the provider stipends from June 5, 2025, through June 30, 2026.

Rationale for Recommendation

By offering these educational opportunities and recognizing their commitment with stipends, CalOptima Health demonstrates its ongoing commitment to collaborative and respectful partnerships with our providers in achieving genuine excellence in care.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Excellence in Care: Advancing Practice and Quality Performance Flyer
2. GA 3202: CalOptima Health Signature Authority

/s/ Michael Hunn *05/30/2025*
Authorized Signature **Date**

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Excellence in Care:
Advancing Practice and Quality Performance

Medical Doctor | Nurse Practitioner | Physician Assistant | Midwife

Thank you for your continued partnership and dedication to providing the best care to your patients. We are pleased to invite you to an evening hosted by CalOptima Health OneCare (HMO D-SNP), a Medicare Medi-Cal Plan, focused on empowering physicians and health care staff with strategies to enhance quality of care, optimize clinical practice and improve performance ratings. The seminar will focus on your Medicare patients.

Scheduled Speaker:



Andrew Golden, M.D.
Medical Director, SullivanLuallin Group

Topic:

- Leading to a Positive Patient Experience

Who should attend:

- Medical directors
- Physicians
- Nurse practitioners
- Physician assistants
- Practice managers

Date	**Thursday** **June 12, 2025**
Time	**6–8 p.m.** Dinner served at 6 p.m.
Location	**Hotel Fera** 100 The City Dr. S Orange, CA 92868

Please **RSVP** by **Monday, June 9, 2025** through this **link** or the QR code.
Space is limited.

For questions, please email **providerservicesinbox@caloptima.org**.

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OneCare
CalOptima Health

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Policy:	GA.3202
Title:	**CalOptima Health Signature Authority**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 10/31/2024*
Effective Date:	03/01/2012
Revised Date:	10/01/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy sets forth the requirements for the execution of any document binding CalOptima Health in any manner.

II. POLICY

A. A CalOptima Health officer or employee may not expend any funds or take any other action on behalf of CalOptima Health, unless the Board of Directors (Board) has approved such expenditure or action, or delegated its power to that officer or employee, subject to an articulated standard.

B. No document of any type whatsoever that binds CalOptima Health to undertake or refrain from undertaking any action, or to expend any CalOptima Health funds, shall be entered into except pursuant to this Policy.

C. In order for any document to bind CalOptima Health, the Board of Directors must have: (1) appropriated funds for the purpose identified in that document, (2) authorized the subject matter of the underlying action, and (3) the document must be executed by an authorized CalOptima Health representative, as identified in this Policy.

D. Amendments or other changes to any document binding CalOptima Health must be approved and executed in the same manner as the original document, except for minor price deviations, as provided within this Policy.

III. PROCEDURE

A. Board of Directors Appropriation: Except in emergency circumstances, as set forth CalOptima Health Policy GA.5002: Purchasing, no money may be expended for any purpose unless that money has been appropriated by the Board of Directors, through the operating or capital budget or individual Board action, or through a budget allocation change, in accordance with CalOptima Health Policy GA.5003: Budget Approval and Budget Reallocation, and the subject matter of the expenditure has been approved by the Board of Directors, as set forth in this Policy

B. Board of Directors Approval: Except as specified in this policy, no document binding CalOptima Health shall be entered into except pursuant to the approval of the CalOptima Health Board of Directors. In approving, the Board may delegate to a CalOptima Health officer the authority to

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enter into agreements that memorialize or are related to the approved action, subject to the assistance of legal counsel, rather than approving a specific binding document. Such approval must be through one of the following means:

1. Individual Board Action: To constitute an authorization though individual Board action, that action must either identify the subject matter of the authorization with reasonable specificity to allow the Board to make an informed decision and to allow staff to proceed without requiring any further fundamental policy decisions to be made, and must specify the nature and scope of that subject matter, such as amount, duration, reporting, or other limitations or requirements, as may be appropriate to the subject matter. Documents regarding arrangements in which the compensation is based in any part on monies recovered or costs avoided by the arrangement (contingency fee contracts) may only be entered into on the basis of a specific, individual Board action.

2. Operational or Capital Budget: To constitute an authorization through inclusion in CalOptima Health's operational or capital budget, expenditures must appear in a budget line item presented to the Board, be related to a Board-approved program or service, and meet the following requirements:

    a. Healthcare goods and services (for the direct provision of Covered Services*****): The Board of Directors must approve, in the operating budget, an amount related to the healthcare or related service, and the expenditure must be pursuant to the criteria approved by the Board in an individual Board action, such as rates or rate methodologies, when adopted.

    b. Non-healthcare-related goods and non-professional services: To constitute an authorization through inclusion in the operating or capital budget, non-healthcare-related goods, non-professional services or other expenditure items must appear in a budget line item presented to the Board, specifying the following:

        i. The description of specific goods, services or other expenditure;

        ii. The number or duration of the goods, services or other expenditure items if available; and

        iii. The dollar amount of the expenditure.

    c. Non-medical professional services: Excluding those professional services contracts that must be authorized by direct Board action for legal or policy reasons, to constitute an authorization through inclusion in the operational or capital budget, non-medical professional services expenditure items must appear in a budget line item presented to the Board, specifying the following:

        i. The specific type of professional services to be obtained (e.g., actuarial, legal, management consulting, program evaluation.), and the type of firm that would provide them (e.g., law firm, consultant, architect, engineer);

        ii. The objective of the professional services; and

        iii. The amount of the expenditure.

C. Board of Directors: The Board authorizes the CEO to enter into a document binding CalOptima Health under the following circumstances:

1. An amendment to a contract with the Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid Services (CMS) if that amendment:

    a. Contains only non-substantive changes, as determined by legal counsel;

    b. Contains only changes made to comply with existing law, as determined by legal counsel; and

    c. Does not contain rate changes.

2. A CalOptima Health Policy and Procedure (P&P) if that P&P contains:

    a. Non-substantive changes; or

    b. Substantive changes in compliance with contractual requirements subject to legal review and concurrence.

D. Signature Authority: Documents executed pursuant to Board Authority, as identified in Section III.B of this Policy, may only be executed by the person expressly authorized to sign.

1. For authorizations that specify the signature authority in individual CalOptima Health Board Action Agenda Referral (COBAR), all related binding documents shall be executed by the person expressly authorized to sign.

2. For authorizations that do not specify the signature authority in individual COBAR, all related binding documents shall be executed as follows:

    a. Healthcare goods and services: For binding documents (such as contracts, amendments, consents to assignment, and Letters of Agreement (LOA)), including all those related to procurement of any goods and services that are Covered Services under any of CalOptima Health's lines of business, (e.g., those items budgeted under Section III.B.2.a):

        i. Except as provided in subsection ii of this Section, execution shall be by the Chief Executive Officer (CEO) or the Chief Operating Officer (COO).

        ii. For CalOptima Health Direct (COHD) contracts that contain no changes from the standard boilerplate contract and are for rates that do not exceed the Board of Director approved rates for the healthcare goods and services, execution may be by the CEO, COO, or the Executive Director, Network Operations.

    b. Procurement and Vendor Management Department binding documents (such as contracts, amendments, consents to assignment, and purchase orders), for non-healthcare-related goods and services (e.g., those items budgeted under Sections III.B.2.b and III.B.2.c) shall be executed by the:

        i. CEO and the Chief Financial Officer (CFO), for documents involving an amount of $250,000 or more;

            a) For those contracts of $250,000 or more, the COO shall have delegated signature authority in the absence of either the CFO or the CEO.

        ii. CEO for documents for less than $250,000;

        iii. CFO for documents for $100,000 or less;

iv. Controller or the Director of Vendor Management for documents for $25,000 or less; and

v. Purchasing Manager for documents for $10,000 or less.

vi. Price term modifications in documents where payment is on a time and materials or per item basis, and that do not exceed 10% of the original price term, either separately or cumulative, may be executed based on the price term increase amount. All other document modifications must be executed in the same manner as the original contract.

c. Emergency expenditure binding documents, related to emergency expenditures, as defined in CalOptima Health Policy GA.5002: Purchasing, shall be executed by the CEO or their Designee.

d. Government program contracts, documents that legally or by their terms require the signature of the governing body, and real property transaction documents (including leases) shall be executed by the Chair of the Board of Directors.

e. Employee reimbursements must be made, in accordance with the CalOptima Health Policy GA.5004: Travel and Business Meal Policy.

f. All Other binding documents (e.g., Memoranda of Understanding (MOU), Settlement Agreements) shall be executed by the CEO or Chair of the Board of Directors.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.5002: Purchasing
B. CalOptima Health Policy GA.5003: Budget Approval and Budget Reallocation
C. CalOptima Health Policy GA.5004: Travel and Business Meal

VI. REGULATORY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/01/2012	Regular Meeting of the CalOptima Board of Directors
09/19/2019	Regular Meeting of the CalOptima Finance & Audit Committee
10/03/2019	Regular Meeting of the CalOptima Board of Directors
08/04/2022	Regular Meeting of the CalOptima Health Board of Directors
09/07/2023	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2012	GA.3202	CalOptima Signature Authority	Administrative
Revised	07/01/2012	GA.3202	CalOptima Signature Authority	Administrative

Action	Date	Policy	Policy Title	Program(s)
Revised	03/01/2013	GA.3202	CalOptima Signature Authority	Administrative
Revised	10/03/2019	GA.3202	CalOptima Signature Authority	Administrative
Revised	10/01/2020	GA.3202	CalOptima Signature Authority	Administrative
Revised	08/04/2022	GA.3202	CalOptima Health Signature Authority	Administrative
Revised	04/01/2023	GA.3202	CalOptima Health Signature Authority	Administrative
Revised	09/07/2023	GA.3202	CalOptima Health Signature Authority	Administrative
Revised	10/01/2024	GA.3202	CalOptima Health Signature Authority	Administrative

IX. GLOSSARY

Term	Definition
CalOptima Health Direct (COHD)	A direct health care program operated by CalOptima Health that includes both COHD -Administrative (COHD -A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment In/Eligibility with CalOptima Health Direct.
Covered Services	Medi-Cal: 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, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health 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: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal 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 the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. 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; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. 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); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. 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, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services;

Term	Definition
	8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. 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 California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. 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); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. 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 twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. 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; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. PACE: Medical services, equipment, or supplies that CalOptima Health is obligated to provide to Participants under the provisions of Welfare & Institutions Code section 14132 and the CalOptima Health PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
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.
Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.

Term	Definition
Memorandum of Understanding (MOU)	An agreement between CalOptima Health and an external agency, which delineates responsibilities for coordinating care for Members.

Continued to a future meeting to allow for further study

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item
27. 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 June 5, 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 its 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 is recommending revisions to Policy AA.1400: Grant Management.

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 organizations eligible to receive grants and the process for monitoring and evaluating progress toward grant performance and any implications on grant payments. The proposed changes from the current version include:

- Added language that eligible grant applicants must be 501(c)(3) nonprofit entities in good standing with the California Secretary of State, cannot have an active grant with CalOptima Health, 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.

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Continued to a future meeting to allow for further study

- 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.

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 June 5, 2025.

Fiscal Impact
The recommended action has no additional fiscal impact.

Rationale for Recommendation
This recommended action has been reviewed with the grant management ad hoc committee of the Board. 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

/s/ Michael Hunn *05/29/2025*
Authorized Signature **Date**

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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

- 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**

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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

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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.

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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

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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

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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.

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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

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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:~~

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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.

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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 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

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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).

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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;

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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.

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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

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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

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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.

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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

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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.

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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;

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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.

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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.

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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:

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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

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.

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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

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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 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.

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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:	06/01/2025
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE ~~☒ Administrative~~

For 20250605 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.

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

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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~~.~~;

iii. Does not have current 501(c)3 nonprofit status;

iv. Is not in good standing with the Secretary of State as a 501(c)3;

v. Has an active grant 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;

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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:

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

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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.

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.

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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.

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.

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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;

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.

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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.

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.

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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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.

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

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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
06/05/2025	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	06/01/2025	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.

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Policy:	AA.1400
Title:	**Grant Management**
Department:	Medi-Cal & CalAIM
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	05/04/2023
Revised Date:	06/01/2025
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

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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.

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

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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;

iii. Does not have current 501(c)3 nonprofit status;

iv. Is not in good standing with the Secretary of State as a 501(c)3;

v. Has an active grant 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;

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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:

Employee Position	**Approval Limit**
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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.

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.

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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.

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.

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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;

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.

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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.

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.

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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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.

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

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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
06/05/2025	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	06/01/2025	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 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.

For 20250605 BOD Review Only

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Continued due to lack of in person quorum at the meeting location

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

28. Authorize 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

Authorize the Chief Executive Officer or designee, to execute 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, to:

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.

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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. If the Board approves the amendment, over the next two months, CalOptima Health staff will work with grantees (Attachment 2) to execute amendments to their agreements using this template, accounting for slight variation across funded programs.

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.

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 *05/29/2025*
Authorized Signature **Date**

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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

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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

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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

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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

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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 June 5, 2025 Board of Directors Meeting – Agenda Item 28

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

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Rev.
6/5/2025

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025 ~~May 1, 2025~~
Regular Meeting of the CalOptima Health Board of Directors

Report Item
29. Approve Actions Related to the Housing and Homelessness Incentive Program

Contacts
Kelly Bruno Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions
Approve 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.

Background
In December 2024, the Board of Directors (Board) approved actions related to the Housing and Homelessness Incentive Program (HHIP) to allocate (i) $600,000 for Priority 2: Infrastructure to Coordinate and Meet Member Housing Needs: Equity Grants (for a total of $1.0 million currently available); (ii) $10.0 million to Priority 3: Partnerships and Capacity to Support Referrals for Service; and (iii) $9.13 million to Priority 4: Innovation and Implementation of Strategic Interventions: Systems Change Projects. The Board also authorized CalOptima Health staff to develop scopes of work to be used in notices of funding opportunities.

Discussion
CalOptima Health staff designed a notice of funding opportunity (NOFO) to distribute up to $500,000 in equity grants, and up to $5.0 million for systems change projects. The NOFO was released to the public on January 22, 2025, via distribution lists and on the CalOptima Health website. CalOptima Health staff conducted a bidders conference for all interested community organizations describing the grant application process, funding priority areas, applicant eligibility criteria, and responded to questions ahead of the open-portal application period, which ran from January 22, 2025, to March 5, 2025. In total, CalOptima Health received 29 applications from 29 unique organizations in total for both the equity and systems change priority grants. Two applications (one from each priority) were removed during the pre-screening process because they did not meet the basic eligibility criteria set forth in the NOFO. The fully reviewed 27 applicant scores can be found in Attachment 2.

Funding Priority	Equity Grants	Systems Change Projects
Total Number of Applications:	11	16
Number of Applications Recommended for Funding:	4	2

CalOptima Health convened a committee of seven grant reviewers to evaluate applications against the scoring criteria presented in the NOFO. Scoring criteria included:

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- Alignment with CalOptima Health core values
- Program Description
- Program Implementation
- Sustainability
- Readiness
- Experience
- Capacity of Applicant
- Evaluation Plan
- References (for Systems Change only)

Evaluators scored all applications on these criteria using a rubric and their scores were averaged to give each application a final score. Applications were required to achieve a minimum average score of 75 to be considered for funding, with applications scoring 80 or higher to be considered very competitive. Most of the applications in both priorities failed to meet the scoring threshold; therefore, staff is recommending that all the top scorers above 75 be awarded grant funding. Recommendations include funding 4 of the 11 equity proposals totaling $200,000 with the remainder of $300,000 tabled for a future NOFO. Two of the systems change proposals received recommendations for full or partial funding totaling $2.5 million with the remaining $2.5 million tabled for a future NOFO.

Upon approval of this action, the remaining total funds available to award under the HHIP are $17.43 million in the priority areas identified below. These dollars will be awarded through future competitive NOFOs.

NOFO Round	Tentative Release Date	Priority Area	Total Funds Available to be Awarded (in millions)
Round 5	Q3 2025	Priority 3: Capital Projects	$10.00
Round 6	Q1 2026	Priority 2: Equity Grants	$0.80
		Priority 4: System Change Grants	$6.63
		Total	**$17.43**

With Board approval, staff would like to proceed with prompt development and execution of grant agreements with the organizations listed in Attachment 3. Staff will provide oversight of the grant pursuant to CalOptima Health Policy AA.1400p: Grants Management and will return to the Board to provide updates on the status of these grants at future meetings.

Fiscal Impact

The recommended action has no additional fiscal impact. The total amount of the proposed grants is $2.7 million. A previous Board action on December 5, 2024, allocated up to $19.73 million to fund Equity grants for programs serving underrepresented populations (Priority 2), Capital projects (Priority Area 3), and System Change projects (Priority Area 4). These allocations are sufficient to fund the recommended action. CalOptima Health reserves the right to recoup funds for lack of demonstrated effort or for not meeting grant requirements.

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Rationale for Recommendation

This recommended action has been reviewed with the grant management ad hoc committee of the Board. Funding these programs will aid CalOptima Health in best serving its members experiencing homelessness, will ensure our CalAIM providers are operating in a strong and connected system of homelessness services, and will support our efforts to ensure health equity across our membership.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. Scores of HHIP Round 4 Applicants
3. Organizations Selected for Award and Recommended Amounts
4. Presentation on HHIP: NOFO Round 4 Recommended Funding Decisions
5. Grant Award Agreement Template

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 1, 2022	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$36.5 million
March 2, 2023	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$19.25 million
June 2, 2023	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$52.3 million
December 7, 2023	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$25 million
April 4, 2024	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$16.18 million
May 2, 2024	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$25 million
December 5, 2024	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$19.73 million

/s/ Michael Hunn *05/29/2025*
Authorized Signature **Date**

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Attachment to the June 5, 2025 Board of Directors Meeting – Agenda Item 29

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Orangewood Foundation	1575 17th St.	Santa Ana	CA	92705
Big Brothers Big Sisters of Orange County and the Inland Empire	1801 E. Edinger Avenue, Suite 101	Santa Ana	CA	92705
Hub for Integration, Reentry & Employment	308 W Chapman Ave #333	Orange	CA	92856
The Hub OC	1439 W. Chapman Ave. Ste. 196	Orange	CA	92868
Action Alliance Foundation	510 S Harbor Blvd	Fullerton	CA	92832
Mercy Health	2000 E. Fourth St.	Santa Ana	CA	92705

SCORES OF HHIP ROUND 4 APPLICANTS

	Equity Grant Proposals	**Score out of 100**	**Funding Recommendation**	**Amount**
1	Hub for Integration, Reentry & Employment	83	Fund	$50,000
2	The Hub OC	82	Fund	$50,000
3	Action Alliance Foundation	80	Fund	$50,000
4	Mercy Health	80	Fund	$50,000
5	Cancer Kinship	69	Do Not Fund	--
6	Beyond Blindness	68	Do Not Fund	--
7	Unidos South OC, Inc.	68	Do Not Fund	--
8	American Academy of Pediatrics - Orange County	67	Do Not Fund	--
9	Recovery Road, Inc.	66	Do Not Fund	--
10	Innovative Housing Opportunities, Inc.	66	Do Not Fund	--
11	The H4H Foundation	57	Do Not Fund	--
			TOTAL	**$200,000**

	Systems Change Projects Proposals	**Score out of 100**	**Funding Recommendation**	**Amount**
1	Orangewood Foundation	92	Fund	$1,500,000
2	Big Brothers Big Sisters of Orange County and the Inland Empire	87	Fund	$1,000,000
3	LeadingAge California Foundation	74	Do Not Fund	--
4	Volunteers of America of Los Angeles	74	Do Not Fund	--
5	Friendship Shelter, Inc.	73	Do Not Fund	--
6	Alianza Translatinx	64	Do Not Fund	--
7	Public Law Center	64	Do Not Fund	--
8	Orange County's United Way	63	Do Not Fund	--
9	South County Outreach	60	Do Not Fund	--
10	StandUp for Kids Inc.	58	Do Not Fund	--
11	The Priority Center, Ending the Generational Cycle of Trauma, Inc	56	Do Not Fund	--
12	The Cambodian Family	54	Do Not Fund	--
13	WISEPlace	53	Do Not Fund	--
14	Southland Integrated Services Inc.	53	Do Not Fund	--
15	The Kennedy Commission	50	Do Not Fund	--
16	OneOC/People for Housing	46	Do Not Fund	--
			TOTAL	**$2,500,000**

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Attachment 3 to the June 5, 2025 Board of Directors Meeting – Agenda Item 29

ORGANIZATIONS SELECTED FOR AWARD AND RECOMMENDED AMOUNTS

Name	Grant Amount
Systems Change Projects	
Orangewood Foundation	$1,500,000
Big Brothers Big Sisters of Orange County and the Inland Empire	$1,000,000
Total	**$2,500,000**
Equity Grants	
Hub for Integration, Reentry & Employment	$50,000
The Hub OC	$50,000
Action Alliance Foundation	$50,000
Mercy Health	$50,000
Total	**$200,000**

Housing and Homelessness Incentive Program Notice of Funding Opportunity Round 4 Recommended Funding Decisions

Board of Directors Meeting

June 5, 2025

Kelly Bruno-Nelson, Executive Director, Medi-Cal and CalAIM

Our Mission

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

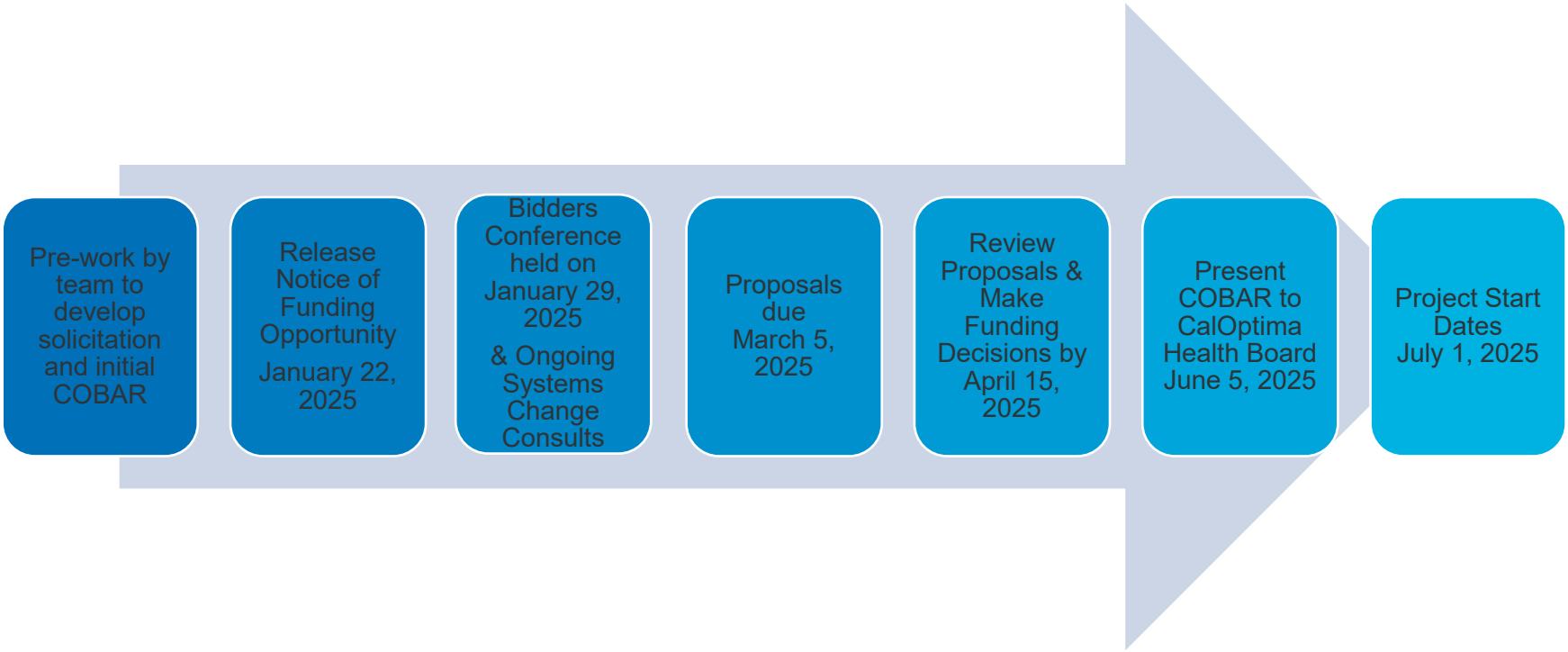
Our Vision

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.

Purpose of Housing and Homelessness Incentive Program (HHIP) Funding

- This funding opportunity was made possible from incentive dollars earned from DHCS through HHIP for the purpose of addressing homelessness.
- Through these investments we attempt to:
  - Build local provider capacity to provide housing and critical services to our members experiencing homelessness.
  - Improve the homeless system of care across Orange County.
  - Identify and cultivate new providers that address the range of social issues faced by our members experiencing homelessness and are at greater risk for health disparities.
  - Build out additional partnerships to expand network of Enhanced Care Management and Community Supports providers.

Solicitation and Review Process



Equity Scoring Criteria

	Criterion	Maximum Points	Description of basis for assigning points
1	CalOptima Health core value alignment	15	Project is trauma-informed, inclusive, non-residency restricted, low barrier, person-centered, and aligned with housing-first and harm-reduction principles.
2	Program Description	20	Program description is clear and concise. Articulate the problem to be solved, propose a feasible solution, and demonstrate how success or progress can be achieved.
3	Program Implementation	15	Plan is complete and includes specific objectives, logical and feasible activities, as well as clearly defined measures of success.
4	Sustainability	5	Program or projects is sustainable beyond this funding opportunity if funding is awarded or is time-bound and does not require continuous funding.
5	Readiness	10	Projects that can launch soon after grant award will receive more points.
6	Experience	15	Expertise in providing proposed services and/or implementation of similar projects in the past. Must be clearly articulated in application.
7	Capacity of Applicant	10	Able to demonstrate financial and management capacity to carry out the project, as evidenced in the submission of required materials in application portal.
8	Evaluation Plan	10	Applicant clearly articulates a feasible and well thought out plan for evaluating project success.
	Total Earnable Points	**100**	

Systems Change Scoring Criteria

	Criterion	Maximum Points	Description of basis for assigning points
1	CalOptima Health core value alignment	10	Project is trauma-informed, inclusive, non-residency restricted, low barrier, person-centered, and aligned with housing-first and harm-reduction principles.
2	Program Description	15	Program description is clear and concise. Articulate the problem to be solved, propose a feasible solution, and demonstrate how success or progress can be achieved.
3	Program Implementation	10	Plan is complete and includes specific objectives, logical and feasible activities, as well as clearly defined measures of success. County-wide impact for systems change programs.
4	Sustainability	**20**	Program or projects is sustainable beyond this funding opportunity if funding is awarded or is time-bound and does not require continuous funding.
5	Readiness	**5**	Projects that can launch soon after grant award will receive more points.
6	Experience	15	Expertise in providing proposed services and/or implementation of similar projects in the past. Must be clearly articulated in application.
7	Capacity of Applicant	10	Able to demonstrate financial and management capacity to carry out the project, as evidenced in the submission of required materials in application portal.
8	Evaluation Plan	10	Applicant clearly articulates a feasible and well thought out plan for evaluating project success.
9	**References**	**5**	**Applicants are required to provide three references; did checks on selected awardees**
	Total Earnable Points	**100**	

Proposals Received

Grant Type	Maximum Allocation	Total Funding Requested	Proposals Received & Evaluated*	Proposals To Be Funded
Systems Change	$5,000,000	$20,906,913	16	2
Equity Grants	$500,000	$549,686	11	4

*Two proposals were removed prior to evaluation because they did not meet the basic eligibility requirements. Additionally, proposals must have received a score of 75 or higher during evaluation to quality for grant funding.

Equity Grants

- CalOptima Health is seeking proposals to cultivate new providers that address the range of social issues faced by our members experiencing homelessness and are at greater risk for health disparities.

Organization Name	Total Funding Request	Funding Award	Brief Description
Hub for Integration, Reentry & Employment*	$50,000	$50,000	Support for Jobs Not Jails program, which serves formerly incarcerated people of all ages and conviction types in Orange County, who are facing challenges with stable housing, employment, and mental health services
The Hub OC	$50,000	$50,000	Support for expansion of the LINKS Project to weekend hours; LINKS addresses key Social Determinants of Health impacting housing stability by bringing together medical providers, housing navigators, employment services, and essential resources.
Action Alliance Foundation	$50,000	$50,000	Support for expansion of their recovery residences for individuals experiencing homelessness seeking to live an alcohol and drug-free life, promoting dignity, respect and equal access to our residents during a time of crisis.
Mercy Health*	$50,000	$50,000	Support Mercy Health's project, Bridging the Gap: Housing Stability Outreach and Referral in Community Pharmacies, employs a strategic approach to combating housing instability among CalOptima members by integrating resource navigation services directly into community pharmacies.

* Nonprofit Healthcare Academy graduate.

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CalOptima Health

Systems Change

- CalOptima Health is seeking proposals that have demonstrable impact on the county's system of care set up to serve people experiencing homelessness. These projects are expected to have county-wide implications on how effectively individuals are identified, served and supported.

Organization Name	Total Funding Request	Funding Award	Brief Description
Orangewood Foundation	$1.5 M	$1.5 M	Launch the Housing Solutions for Enhanced Probation Youth Outcomes project to support the gradual yet successful return of probation youth to their families and promote housing stability for that population. Partner with the Orange County Probation Department for implementation.
Big Brothers Big Sisters of Orange County and the Inland Empire	$1.5 M	$1.0 M	Collaborate with the Orange County Department of Education to establish a county-wide mentorship program, ensuring every school district and college in Orange County has access to high-quality, evidence-based mentoring programs as part of the OC Pathways project.

Next Steps

- Will execute grant agreements during the month of June and will be effective by July 1st.
- Funded programs launch July 1, 2025.
- HHIP Notice of Funding Opportunity (NOFO) Round 5 is planned for Q3 of 2025.

CalOptima Health

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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**.

[CalOptima to add description of transitional housing program].

2. **Grant Program Requirements**. Grantee shall do all of the following:

[CalOptima to add description of transitional housing program].

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.

Continued to a future meeting to allow for further study

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

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

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Donna Laverdiere, Executive Director, Strategic Development, (714) 986-6981

Recommended Actions

1. Authorize closing the Board-approved Intergovernmental Transfer 7 initiative with the Coalition of Orange County Community Health Centers to Increase Access to Medication-Assisted Treatment and designate remaining balance of $300,000 as available for allocation to deliver enhanced services for Medi-Cal members.

Background and Discussion

On August 1, 2019, the CalOptima Health Board of Directors (Board) approved the allocation of $19.1 million in Intergovernmental Transfer (IGT) 6 and 7 funds toward community grants and internal projects. One of the projects approved by the Board was a $6 million grant to the Coalition of Orange County Community Health Centers (the Coalition) to increase access to medication assisted treatment (MAT).

CalOptima Health and the Coalition entered into a grant effective October 1, 2019, to increase access to medication through a MAT care collaborative in Orange County, known as MATConnect. The MATConnect grant was a five-year program, scheduled to end September 30, 2024. Under the terms of the grant agreement, the Coalition is required to submit quarterly and annual progress reports, as well as a final report, to inform CalOptima Health of the progress toward the grant's funding objectives. Completion of these reports is a condition of grant funding. The annual progress report for the reporting period October 1, 2023, through September 30, 2024, was due on October 30, 2024. The final report for the entire MATConnect grant period was also due October 30, 2024. Under the terms of the grant, CalOptima Health was required to withhold $300,000 of the final grant payment conditional upon the Coalition's submission of an acceptable final report.

The Coalition has not submitted the annual report for the period October 1, 2023, through September 30, 2024, or the final report. Therefore, CalOptima Health recommends the termination of the grant agreement. Upon Board approval, staff will notify the Coalition, and the termination will be effective 30 days after receipt of notice.

Fiscal Impact

The recommended actions will make $300,000 in IGT funds available toward future initiatives to deliver enhanced services for Medi-Cal members.

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Continued to a future meeting to allow for further study

Rationale for Recommendation

The recommended action is consistent with the terms of the grant agreement and 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 *05/29/2025*
Authorized Signature **Date**

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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

Continued due to lack of in person quorum at the meeting location

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

31. Authorize Extension of Grant Award Agreement with Mind OC for the Be Well OC Irvine Campus

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Donna Laverdiere, Executive Director, Strategic Development, (714) 986-6981

Recommended Action

Authorize the Chief Executive Officer to extend 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 $12.7 million to Mind OC for the grant and has $2.3 million remaining in the escrow account.

Based on progress reports from Mind OC, completion of this construction project is 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.

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- Continue construction efforts for other planned installation activities surrounding interior and exterior details.

Based on the above plan, staff requests the Board authorize 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 *05/30/2025*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MindOC	18650 MacArthur Blvd., Ste 350	Irvine	CA	92612

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item
32. Approve Actions Related to Contracts for Legal Services

Contacts
John Tanner, Chief Compliance Officer, (714) 867-9654

Recommended Actions
1. Ratify a contract with Bird, Marella, Rhow, Lincenberg, Drooks, & Nessim, LLP for legal services effective September 16, 2024, and ratify an amendment to that contract effective May 30, 2025, through December 31, 2025; and
2. Ratify a contract with Liebert Cassidy Whitmore, PC, to provide legal services effective May 12, 2025, through December 31, 2025.

Background and Discussion
CalOptima Health uses a full external legal services model and does not employ legal staff. Consistent with Section II.C.7.b of CalOptima Health Policy GA.5002: Purchasing, and industry practice, CalOptima Health contracts directly for legal services and does not utilize a competitive procurement process due to the nature of these services. CalOptima Health contracted with two legal firms to address unanticipated legal needs to support Board of Directors approved initiatives.

Bird Marella Contract
CalOptima Health contracted with Bird, Marella, Rhow, Lincenberg, Drooks, & Nessim, LLP, (Bird Marella) on September 16, 2024, for special legal services. The contract provided for Bird Marella to bill for services through CalOptima Health's general counsel legal firm, Kennaday Leavitt, PC (Kennaday Leavitt), and authorized Bird Marella to accept payment on behalf of CalOptima Health from Kennaday Leavitt.

The amendment to the contract, effective May 30, 2025, directs Bird Marella to submit invoices to CalOptima Health and accept payment directly from CalOptima Health.

The fee schedule for the contract with Bird Marella is as follows:

Services	Rates
Principals	$715 – 1600 / hour
Associates	$610 – 800 / hour
Of Counsel	$760 – 1420 / hour
Senior Counsel	$760 – 1420 / hour
Paralegals and litigation support personnel	$160 – 550 / hour

LCW Contract
CalOptima Health contracted with Liebert Cassidy Whitmore, PC, (LCW) on May 12, 2025, for legal services pertaining to employment relations and personnel matters.

The fee schedule for the contract with LCW is as follows:

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Services	Rates
Partners	$485 / hour
Senior Counsel	$400 / hour
Associates	$295 - $380 / hour
Labor Relations / HR Consultant	$315 / hour
Classification and Compensation Consultant	$230 / hour
Paralegals	$165 / hour
E-Discovery Specialists	$185 / hour
Law Clerks	$180 - $200 / hour
Photocopies	$0.15 / copy

Fiscal Impact
The funding for the estimated costs for the contracts will be requested through a separate Board action.

Rationale for Recommendation
This action is recommended by the Legal Ad Hoc Committee of the Board. The action will enable CalOptima Health to access necessary legal services.

Concurrence
Legal Ad Hoc Committee of the Board

Attachments
1. Entities Covered by this Recommended Action

/s/ Michael Hunn *05/30/2025*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Bird, Marella, Rhow, Lincenberg, Drooks & Nessim, LLP	1875 Century Park East, 23rd Floor	Los Angeles	CA	90067-2561
LCW Liebert Cassidy Whitmore	6033 West Century Boulevard, 5th Floor	Los Angeles	CA	90045

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 5, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item
33. Authorize Unbudgeted Expenditures and Appropriate Funds for Legal Services

Contact
John Tanner, Chief Compliance Officer, (714) 867-9654

Recommended Actions
Authorize unbudgeted operating expenditures and appropriate funds in an amount up to $2.1 million from existing reserves to fund legal services through December 31, 2025.

Background
On June 6, 2024, the CalOptima Health Board of Directors (Board) approved the CalOptima Health Fiscal Year 2024-25 Operating Budget (FY25 Budget). The budget included $3.35 million for professional legal services. On December 5, 2024, the Board approved an additional allocation of $2.5 million for unanticipated legal expenses that are critical to implementation of Board-approved strategic and operational initiatives.

At that time, management estimated costs for the additional legal services as follows

Activity	**Estimated Cost (amount not to exceed)**
Additional compliance and audit related activities	$750,000
New and anticipated litigation	$1,000,000
Knox-Keene licensure activities (upon approval of ordinance change)	$750,000
TOTAL	$2,500,000

Discussion
As noted above, in the December 2024 action, the Board allocated $2.5 million for unanticipated legal expenses. Based on the current utilization of services, an allocation of $1.45 million from existing reserves is needed to fund operating expenses in the current fiscal year, and $650,000 is needed to fund additional compliance and audit related activities in Fiscal Year 2025-26. Please see the table below for more information.

	Estimated Cost (amount not to exceed)		
Activity	**FY 2024-25**	**FY 2025-26**	**Proposed Action Total Request**
Additional compliance and audit related activities	$450,000	$650,000	$1,100,000
General legal services	$1,000,000	--	$1,000,000
TOTAL	$1,450,000	$650,000	$2,100,000

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Fiscal Impact
The recommended action is unbudgeted. An appropriation of up to $2.1 million from existing reserves will fund continuation of legal services to support Board-approved initiatives.

Rationale for Recommendation
This action is recommended by the Legal Ad Hoc Committee of the Board. The action is necessary to cover legal services costs that were not planned or known at the time of the FY25 Budget approval.

Concurrence
Legal Ad Hoc Committee of the Board

Attachments
None

/s/ Michael Hunn *05/30/2025*
Authorized Signature **Date**

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